



SHINING A LIGHT BEHIND CLOSED DOORS

Report of the Jack Brockhoff Foundation Churchill Fellowship
to better protect the human rights and dignity of people with
disabilities, detained in closed environments for compulsory
treatment, through the use of innovative legal services

ELEANORE FRITZE

December 2015

Eleanore Fritze is a Melbourne-based lawyer who has worked in various roles at Victoria Legal Aid (VLA) for the last 10 years. She has a longstanding commitment to assisting people with disabilities to access and meaningfully participate in the justice system. In 2010, she was the inaugural duty lawyer in the 'Assessment and Referral Court List', a pilot therapeutic criminal court for people with various disabilities and complex needs.

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THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by ELEANORE FRITZE – 2014 Churchill Fellow

THE JACK BROCKHOFF FOUNDATION CHURCHILL FELLOWSHIP
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Eleanore Fritze
13 December 2015



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In addition, this research was conducted with the support of my employer, Victoria Legal Aid ('VLA'), for which I am also very grateful.

This report brings together a wide range of information and insights generously shared by the people I met and/or connected with during the course of this research project. I had so many inspiring conversations with truly impressive people, and I am extremely grateful to everyone for their willingness to donate their time and contribute so openly, especially the service users who shared their personal stories with me. I am also particularly grateful to those who connected me to other people and who have kept in contact with me beyond the research period – I look forward to sharing ideas and collaborating with you into the future. In this regard, Emeritus Professor Michael Perlin, who I interviewed on the first day of this project and has taken a great interest since then, warrants a special mention.

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¹
For more information about the
Jack Brockhoff Foundation,
see <<http://www.jackbrockhoff.org.au/>>.

LIMITATIONS OF RESEARCH AND DISCLAIMER

The topic of this fellowship is so broad that a single report (even one so long!) cannot hope to comprehensively do justice to it. As explained in Part 1B below, I commenced this research with particular questions in mind – questions that are of interest and seemed pertinent in light of our practice experience in Victoria. However, I did not know what I would find overseas. From my initial questions and contacts in each jurisdiction, the research unfolded in an inquisitive, iterative fashion. Often, the most interesting information and contacts emerged quite late in my time in each place, through unexpected means.

Approaching the research in such an exploratory rather than rigid or systematic fashion – especially within a limited timeframe – necessarily means there are gaps. There are doubtless many interesting services and people who could have provided additional, insightful – and potentially even contradictory – information but who I did not get a chance to speak with during the confines of this project. In addition, I had planned to attend an intensive course at the Central European University in Budapest on ‘mental disability law in practice’, focusing on the conduct of strategic disability rights litigation based on international law, but unfortunately the course did not run in 2015. Accordingly, the report should be seen as a snapshot of information and ideas rather than a comprehensive or definitive resource.

My intention with this report was to capture the new information gathered through this fellowship, information that would otherwise be unknown or inaccessible to an Australian audience. To that end, I have not sought to summarise existing knowledge or incorporate the work of others which is already in the public domain. Not all information gathered during the fellowship has been included in this report, which is in no way a reflection on those who supplied it. However, even where not directly referenced, the conversations and insights of each person I met have played a role in guiding the creation of this report.

This project and the report was necessarily approached from a practising lawyer’s perspective, as that is what I know and can speak about with authenticity. To that end, the recommendations are primarily directed towards lawyers and legal services as well. During my research, I sought to connect with service users and people with lived experience of the local mental health and legal systems in order to incorporate their unique expertise and perspectives. However, the limited extent to which I was able to do this in practice is a limitation of this research.

This report has been compiled within a few short months following the conclusion of the formal overseas research period. There was limited time to digest the information, cross check it and learn more about the interesting issues which arose. To minimise errors and increase the validity of my research, the draft report was sent back to each contributor for their review and optional further input prior to publication. Nevertheless, if any errors remain, they remain mine.

While VLA has provided significant support for me to undertake this fellowship, the content remains mine and the views expressed in the report do not necessarily represent the views of VLA. Similarly, as mentioned in the research program (Appendix 2), a number of contributors specifically noted that they spoke to me in their individual capacity.

EXECUTIVE SUMMARY

The Jack Brockhoff Foundation Churchill Fellowship to better protect the human rights and dignity of people with disabilities, detained in closed environments for compulsory treatment, through the use of innovative legal services

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Definitions of terms in bold can be found in the glossary at the very end of this report, along with a list of acronyms. The terms are also defined in the body of the report where they first appear.

Despite the development and adoption of the United Nations' Convention on the Rights of Persons with Disabilities ('**CRPD**') in 2006, we are regularly and soberly reminded that the human rights of **people with disabilities** are still often disrespected or outright violated.

Among the most significant current laws and practices impacting on the rights of people with disabilities are those that permit people with disabilities to be detained for **compulsory treatment**. When people are detained and subjected to compulsory treatment, many of their rights will be limited, including their rights to liberty, to not to be subjected to medical treatment without consent, to privacy and to be free to make decisions about a wide range of matters in their life. It has traditionally been accepted that such laws and practices are a permissible limitation on human rights, provided certain safeguards are in place. However, this is increasingly the subject of significant debate.

Irrespective of whether the domestic legal framework is considered to be compatible with human rights, numerous additional factors push against respect for human rights at a practical, operational level when a person is detained in a **closed environment**. Accordingly, effective, practical safeguards are necessary to ensure that laws which permit the detention and compulsory treatment of people with disabilities are applied and operate correctly in practice. **Lawyers** and legal services are one such important rights-protecting safeguard.

Drawing on my experiences of providing such legal services through the Mental Health and Disability Law program ('**MHDL**') at Victoria Legal Aid ('**VLA**') (Victoria's primary mental health and disability legal service), I wanted to explore how lawyers can best protect the human rights and dignity of people with disabilities who have been detained in closed environments for compulsory treatment. Over eight weeks between 1 May 2015 and 28 August 2015, I travelled to New York, Washington DC, England, Vienna and Budapest. I visited mental health and disability facilities, observed legal services and court/tribunal hearings in action, attended courses and conferences and interviewed almost 50 people, including practising lawyers and barristers, academics, psychiatrists, advocates, judges and service users (see research program in Appendix 2). Rather than seeking to create a comprehensive or definitive resource, this report captures the information gathered and presents a snapshot of ideas relevant to Victoria arising from what I learnt, with a focus on mental health legal services and strategic advocacy.

Chapter 1 provides further background information and the rationale for this research, as well as an overview of the research program and methodology.

Mental health legal services in context

Mental health legal services in New York and England, the two jurisdictions I focused on, are delivered in very different ways – by a single, statutorily-mandated legal service attached to the Appellate Division of the Supreme Court in New York (the Mental Hygiene Legal Service, ‘**MHLS**’), and by hundreds of disparate private law firms in England. Chapter 2 sets out descriptive and contextual information relating to mental health legal services in New York and England, including:

- The general legal context and rights frameworks;
- Domestic laws relating to the detention and compulsory treatment of people with mental illness;
- The use of compulsory treatment laws;
- How **mental health hearings** are conducted, and by whom;
- Who provides mental health legal services; and
- The availability of other providers of legal or advocacy services to people with disabilities in the same jurisdiction.

These contextual factors significantly impact on the way in which mental health legal services are structured and delivered. It is accordingly necessary to understand these factors in order to consider to what extent their efforts to protect their clients’ rights might be relevant or replicable in Victoria. This information also helps make sense of the more analytical parts of this report.

Mental health legal services in action

Chapter 3 looks at how mental health legal services act and seek to influence others to protect the rights of individual clients with disabilities who are detained for compulsory treatment in closed environments. The rights focused on in this chapter are statutory rights and human rights to the extent they are protected by the domestic legal system.

How compulsory inpatients obtain legal representation

Whether and how **compulsory inpatients** are able to obtain legal assistance is critical for rights protection, as a lawyer cannot take any steps to assist a person unless they know about and are able to act for them. The stark differences between the limited availability of legal services in Victoria and the situations in New York and England were some of the most striking findings from this project and call out for redress.

Both New York and England have stronger statutory and practical arrangements to ensure that compulsory inpatients are connected with lawyers in a timely fashion. Compulsory inpatients also have much broader entitlements to legal representation for mental health hearings than in Victoria, with New York directly providing legal representation for every person and England committing to funding representation for practically every person subjected to compulsory mental health treatment, including compulsory treatment in the community. In neither jurisdiction is publicly-funded representation limited by the person’s likelihood of success or financial means. Furthermore, unlike Victoria, even those lacking the capacity to instruct a lawyer receive legal services, with England’s Mental Health Tribunal (‘**MHT**’) specifically empowered to appoint a lawyer to represent a person who does not have capacity to make the appointment themselves. Most critically, the legal service systems in New York and England are adequately resourced to meet demand to ensure essentially universal representation at mental health hearings. The broad scope of mental health legal service provision, and the sufficiency of funding, are accepted as necessary to comply with constitutional rights in the US and human rights in England.

Protecting rights in judicial contexts: mental health courts and tribunals

Mental health hearings in England are conducted by the MHT, which is in many ways similar to Victoria's MHT. However, such hearings in New York are conducted by the Supreme Court, which is a comparatively fast-paced, legalistic and public forum. The frequency of permissible hearings in both jurisdictions is more limited than in Victoria.

I found that numerous variables impact directly on rights and/or a lawyer's ability to protect their clients' rights in mental health hearings, including:

- Notice of hearings and access to information;
- The pace and depth of the hearing;
- Whether the **judicial decision-makers** are fixed or vary from hearing to hearing;
- The influence of psychiatrists;
- Respect for and engagement with the person at the centre of the hearing; and
- Judicial attitudes towards legal representatives and the lawyer's role.

Having gained an understanding of the operation of these variables in each jurisdiction, I looked at how lawyers respond and act to protect their clients' rights at mental health hearings. Common themes emerging were:

- Thorough preparation;
- Insistence on due process and fair hearing requirements; and
- Robust advocacy and scrutiny of evidence.

One key reflection was that the more a mental health court or tribunal is inquisitorial and takes a robust, critical approach to the mental health service's evidence, the less legalistic and adversarial (in the sense of combative) the hearings become because the patient's lawyer no longer needs to perform that function in full.

In England, appeals and other legal challenges against decisions of the MHT were also identified as important actions for lawyers to take, both to protect individual rights and to shape the operation of the MHT.

Overall, perceptions of whether New York judicial decision-makers and mental health hearings were rights-respecting depended heavily on which particular judge was presiding. However, perceptions of the English MHT's current functioning were much more consistently positive. The improvement in the MHT's functioning over the last decade was commonly attributed to the volume of legal challenges against its decisions (which facilitate consistent, lawful practices by educating and holding individual decision-makers to account) and its move from the Department of Health to the Ministry of Justice.

Protecting rights in administrative contexts: hospitals and clinicians

Administrative decision-makers such as clinicians play a broad and extremely significant role throughout systems of detention for compulsory mental health treatment, as they are the gatekeepers to the system and are empowered to make a range of rights-limiting decisions. In addition to formal decisions, the general attitudinal culture, policies and conditions within a mental health service, which are created and influenced by administrative decision-makers and other staff, will also have a significant impact on a person's experience of compulsory treatment.

The manner in and extent to which lawyers directly advocate on behalf of their clients in relation to specific administrative decisions, such as the administration of compulsory treatment and the granting of leave, varies considerably between New York and England because of their respective legal frameworks and legal service models in operation. MHLS lawyers are significantly aided in their ability to scrutinise and influence key administrative decisions because their law establishes processes that not only permit but mandate their notification and participation. For instance, the questions of whether and what treatment can be forced on a compulsory inpatient are subject to a formal, two-stage process and are ultimately decided by the Supreme Court, and the MHLS provides legal representation at both stages.

In contrast, lawyers in England, like Victoria, rarely advocate directly in relation to specific administrative decisions because of the predominantly informal and unseen processes through which these decisions are made, as well as the limitations on their role corresponding to the scope of legal aid funding available. However, recognising the very limited role of lawyers, a separate statutory scheme for independent mental health advocacy (**'IMHA'**) was established in England to influence practice and promote human rights behind closed doors by supporting compulsory patients to understand and participate in the decisions that would otherwise be made solely by clinicians or others around them. Similar IMHA services recently commenced in Victoria in August 2015.

While English lawyers rarely advocate directly in relation to specific administrative decisions, they do advocate in two different judicial contexts in order to influence administrative decision-makers: seeking recommendations from the MHT and directly challenging the lawfulness of administrative decisions in higher courts through **judicial review** or litigating a breach of the *Human Rights Act 1998* (UK). The readiness of lawyers to undertake judicial review was frequently identified as having made a significant contribution to the development of a law-abiding and rights-compliant decision-making culture among English clinicians, which shapes how they act in practice. Other factors identified as contributing to this culture of rights compliance were clear statutory roles and responsibilities, the employment of Mental Health Act administrators, the prescriptive **Code of Practice**, the work of the Royal College of Psychiatrists and Care Quality Commission, and service user involvement in quality assurance and other initiatives.

In contrast, in New York, MHLS lawyers play a particular role contributing to the creation of, and reinforcing, rights-respecting conditions and cultures within mental health services through their regular, on-site presence within services and their mandate to directly raise any issues of concern.

One thing emphasised in both jurisdictions was that, to improve compliance and lift standards in practice, it is necessary for lawyers to highlight the risks and 'costs' of unlawful or unfair decisions.

Due to its similar legal framework and the evident impact which lawyers have had, England provides a good model for Victoria to look to in strengthening the human rights culture within mental health services. Accordingly, the longstanding dearth of legal challenges to mental health-related administrative decisions in Victoria is something that should be addressed.

How informally detained people with disabilities obtain legal assistance

Where a person is **informally detained**, there is no external trigger such as a scheduled court or tribunal hearing to prompt the involvement of a lawyer who could provide the person with independent advice about their rights. This means that the person must generally take the initiative to contact a lawyer. However, while an informally detained person may be unhappy with their situation or wish to have greater freedoms, various factors may prevent them from proactively seeking legal assistance.

Unlike England and Victoria, which provide very limited external oversight or scrutiny for informally detained people, New York provides a number of statutory protections to help ensure that any informal patient who does not freely consent to their admission or treatment is able to access legal advice, and also that some periodic, independent legal oversight of their situation occurs.

Following a decision of the European Court of Human Rights (**'ECtHR'**), England has recently brought formality to informal detention for people lacking capacity to consent to the restrictions imposed on them through the 'deprivation of liberty safeguards' (**'DOLS'**) scheme. While DOLS should facilitate rights protection, every person I spoke with said that there are significant problems with the operation of the scheme and it is not a model which Victoria should look to directly emulate.

New York's system is quite appealing as it strikes a balance by ensuring transparency of legal status, readily accessible legal advice and some periodic, independent oversight without formally depriving the person of their liberty. However, it is only effective because there is a designated and adequately resourced legal service to fulfil that role, which Victoria does not have.

Aside from providing direct legal services, there are a range of ways through which lawyers can indirectly reach behind closed doors to help protect the rights of informally detained people with disabilities. The most important method identified was engaging with and influencing those who do go behind closed doors. In the absence of any clear role or mandate for mental health lawyers in Victoria, it is even more important that independent inspectors and others who do have such functions are trained in human rights monitoring, properly resourced and carrying out their functions effectively. This includes identifying and referring on people who may benefit from legal assistance.

Beyond individual legal services: strategic advocacy

There is only so much a lawyer can do to protect their client's human rights in an individual case if:

- The laws, procedures and/or policies governing their situation are fundamentally unfair, inconsistent with human rights or fail to provide essential rights safeguards; or
- Laws, procedures and policies which are rights-protecting on their face are nevertheless routinely interpreted and applied in a way which does not protect those rights.

By pursuing **strategic advocacy**, lawyers promote and seek to protect the rights of a broad cohort of people similarly affected by the particular limitations of the system, many of whom may have never even spoken with a lawyer. Achieving systemic change also prevents people from being negatively impacted by the same issue in the future. Accordingly, lawyers can make a tremendous impact through strategic advocacy in a way which is unlikely to be achievable through legal services focussing purely on the interests of the individual client before them.

Setting the scope and goals of rights-based strategic advocacy

The scope of action and substantive goals that lawyers set for rights-based strategic advocacy in this context vary considerably. Beyond simply trying to protect **negative rights** like liberty and freedom from compulsory treatment to the extent allowed by the domestic legal system, broader and possibly more sophisticated goals for strategic advocacy may include:

- Seeking compliance with international human rights and the CRPD;
- Promoting and seeking protection for a broader range of rights, including **positive rights** to treatment and community-based supports; and
- Tackling issues which affect a specific cohort of people with disabilities (such as intersectional discrimination), rather than dealing only with general disability issues.

Just as I have witnessed in Victoria, people in each jurisdiction told me that the non-availability of adequate accommodation and community supports mean that many people are detained in hospital for longer than they clinically require, and are (re)admitted to hospital in circumstances where it would not have been necessary if they had had adequate community services and supports in place. Accordingly, focussing only on negative rights without also addressing access to housing, treatment, financial support, employment, education and community integration – and ensuring that funding is appropriately directed towards such supports – will be insufficient to protect the rights of people with disabilities.

Accordingly, many disability law organisations and programs I met focus on the protection of their clients' positive rights rather than simply their negative rights. Unlike Victoria, provisions in domestic statutes in both New York and England impose specific obligations on hospitals and related services to provide adequate services and supports for people being discharged from hospital, which give lawyers in these jurisdictions a more direct means of advocating on behalf of their clients around these issues. For a range of reasons, mental health and disability lawyers in Victoria have found it more difficult than their overseas counterparts to devote attention to and gain traction in human rights-based strategic advocacy on behalf of people with disabilities.

Engaging in strategic advocacy

Organisations may take quite different approaches when it comes to engaging in strategic advocacy on behalf of people with disabilities. I explored a range of variables, including how organisations balance providing individual legal services with strategic activities and the extent to which they engage in planning and priority-setting. I also explored how strategic litigation is conducted in different jurisdictions.

Throughout my research, it was regularly reinforced that strategic litigation is important but insufficient to properly advance the protection of rights. Instead, a variety of coordinated strategic activities are necessary. Additional strategies include lobbying, campaigning and conversations with government, shaping public opinion through the media, and monitoring, documenting and researching human rights violations. Which strategies will be most appropriate must be considered in relation to the particular issue and context, including who holds the power that is sought to be influenced.

While they varied in their approaches, the organisations I met were ambitious and creative in how they approached strategic advocacy, particularly in seeking to tackle root causes and big solutions. Inadequate funding, and funding misdirected to the ‘wrong’ end of the system (ie expensive, crisis-driven services and detention facilities rather than preventative, early intervention and community-based supports), were noted by many as critical problems which need to be addressed. Ensuring that what funding there is is directed towards human rights-compliant practices and infrastructure is also important.

Strategic advocacy is resource-intensive and complex. Many people I spoke with said the exchange of ideas through communication and collaboration with others was enriching and valuable for achieving better outcomes. In fact, collaboration is often necessary to achieve the desired reach and impact due to the resource limitations of each individual organisation. Coordination also avoids duplication of effort and so preserves and maximises resources in the sector. Therefore, it is unhelpful for legal services to be isolative or competitive.

Ultimately, the true realisation of human rights requires the hand-in-hand development of law and culture; focussing on the law alone will not work. Cultural change is clearly an impossible task for legal services to take on themselves. However, equipped with a focused human rights lens, lawyers who go into closed environments are uniquely placed to play an important contributory role in shaping public opinion and the development of a rights-respecting culture by sharing their insights and amplifying the voices of the people detained therein.

Cultivating high-quality and effective mental health legal services

In Chapter 5, I look more closely at the lawyers and legal services themselves to learn what factors facilitate high-quality and effective mental health legal services and how quality can be maintained and enhanced.

Note that each organisation is necessarily a product of its founding legislation, funding conditions and/or *raison d’être*. Furthermore, whether an organisation is functioning optimally to protect the human rights and dignity of its clients cannot be considered in isolation from its local context. Accordingly, the search for a single ‘best practice’ or model legal service is perhaps naive.

Factors supporting high-quality and effective legal services

In addition to the personal qualities, attitude and motivation of the lawyers, I found that the following working arrangements and conditions were important in supporting high-quality and effective mental health legal services:

- Adequate time for preparation and reflection;
- Provision of professional support, training and development; and
- Work group, peer support and mentoring.

In addition, two key service model and operational factors were identified as having a significant impact on the quality and efficacy of legal services. The first is whether legal services are undertaken by a single provider or a range of disparate services. There are both strengths and weaknesses associated with each model, including:

- How easily clients can access the service;
- Whether clients have choice and whether firms are competing to serve clients;
- Whether the service has the authority and standing to influence others; and
- How easy it is to develop local knowledge and relationships with health services.

The second key service model variable is the range of work undertaken. Some legal services specialise purely in mental health and/or disability law matters whereas others provide a broader range of legal services. While it would be ideal if a single lawyer could provide all of the legal services a particular client might ever need, clients with multiple legal issues are likely to need multiple lawyers to address their issues. Arguably, whether or not these lawyers work in the same service matters less than how smooth and efficient the referral and transfer of relevant information between them is.

Some legal services also seek to address non-legal issues to support their clients more holistically. In order to provide the most effective legal advice, it is important for lawyers to understand their clients' interconnected non-legal issues and context. There are some benefits to having non-legal and social work services available in-house, including the support they can provide to the lawyers to facilitate better quality legal services. However, it is also important for lawyers to remain focused on their client's wishes and not slip into paternalistic, best interests advocacy.

Finally, the sufficiency of funding and the particular model of funding or remuneration have a significant impact on the way in which lawyers undertake mental health and disability legal services and therefore on the quality of those services. Funding pressure was a common theme. Given the personal qualities and motivations of typical lawyers practising in this field, they are likely to stretch themselves in the face of insufficient funding to (try to) meet demand by working additional, unpaid hours. This is not a sustainable practice and comes at a significant personal cost to the lawyers involved. However, the alternative involves turning away or failing to adequately help people whose human rights are at risk.

Provided the personal qualities, motivation and attitudes of the lawyers are good and lawyers are not pressured to take on more cases than they have the time to properly handle, being on a fixed salary facilitates high-quality, client-focused legal services because considerations of funding and profit cannot influence or dictate the legal advice or service provided. However, depending on the jurisdiction and particular service model, those two preconditions may not necessarily exist.

One of the things I was most pleased to discover during my travels was how well my colleagues at MHDL compare to the high-quality lawyers I encountered overseas. MHDL has the right foundations and personnel to deliver a very effective legal service. However, the existing stressors on our work are significant and potentially unsustainable. Therefore, notwithstanding that some features such as a legislative mandate are not immediately replicable, the operational and service model factors identified in this part are worth close consideration when reflecting on the design and delivery of mental health legal services in Victoria.

Efforts to regulate and improve the quality of mental health lawyers and legal services in England

Principally as a result of concerns about the quality of advocacy, a number of schemes have been implemented in England to regulate and improve the quality of mental health lawyers and legal services. These include the Law Society's mental health accreditation scheme, Legal Aid Agency contract requirements and peer review. England's experience reveals that, particularly where there are funding pressures, the quality of mental health legal services depends on appropriate regulations and the establishment of structural supports and conditions that allow them to flourish.

There are currently no specific restrictions or practice standards in place governing mental health legal services in Victoria. This absence has not negatively impacted on the quality of mental health legal services to date, as almost all services have been provided by a small cohort of specialist lawyers; very few private lawyers have sought to be involved in this work. However, noting what happened in England, this may change. Accordingly, rather than risk exposing people to poor quality services, it would be prudent to pre-emptively develop specific protocols and practice standards to make sure that anyone providing mental health legal services in Victoria does so at a high standard.

Looking back and looking forwards

This fellowship has provided me with a unique opportunity to conceive of new possibilities for mental health and disability legal services in Victoria. My preliminary analysis, conducted within the time constraints of this project, suggests that the recommendations and ideas I have listed at the end of each part of this report (and collated below) may advance the protection of rights of people with disabilities who have been detained in closed environments for compulsory treatment in Victoria. However, the real work now begins to more closely explore the viability and possible implementation of those ideas in practice.

In the short term, this report will be disseminated to relevant stakeholders to draw their attention to and discuss with them the issues and ideas that affect their work and/or which are within their control to progress. Key stakeholders include the MHT, VCAT, the Department of Health and Human Services, the Chief Psychiatrist, the Public Advocate, the Senior Practitioner for Disability, the clinical directors of each mental health service and coalitions of service users. However, this is just the beginning.

Working in collaboration with others to achieve a shared goal was a key theme which emerged during my research. Indeed, in order to be respectful of human rights and thus achieve the project aim, it is essential to engage with and truly value the unique perspective – an alternative form of expertise – of people with lived experience of the issues at hand. We therefore need to strengthen our efforts to engage with others from whom we can learn and with whom we can collaborate to maximise the chances of achieving change. I hope as a result of this fellowship to establish a coalition of thought and practice leaders across the sector in Victoria to discuss these ideas and progress this work.

As one of the few jurisdictions in Australia with broad statutory human rights protection, Victoria should be a leader in this field. While MHDL currently has very limited contact with its counterparts in other states and territories, there would be mutual benefit in establishing a network of mental health and disability legal services across Australia. As this fellowship demonstrates, even quite different jurisdictions experience similar issues and discussing different approaches can be extremely enlightening, even if local solutions ultimately differ.

While the task ahead is rather daunting, the recent volume of disability-related inquiries and law and policy reform suggests we are currently in an environment which is more receptive to ideas about disabilities rights. I am hopeful that, by working together, we can build momentum for real and lasting improvements to strengthen the protection of human rights of people with disabilities in closed environments.

RECOMMENDATIONS AND IDEAS

Consistent with the research topic, these recommendations and ideas are primarily directed towards lawyers and legal services, particularly VLA. However, in order to implement them, many will require the involvement or action of others.

3A. How compulsory inpatients obtain legal assistance

- Request the State provide adequate funding for MHT legal representation in all matters where representation forms part of the safeguards necessary to render the detention and compulsory treatment permissible under human rights law.
 - Collaboratively plan how to engage with the State on this issue.
- In order to plan a response and inform negotiations with its funders, VLA should examine the cost of providing legal representation to all people who should be entitled to legal representation in accordance with human rights principles.
- Noting its obligations as a public authority under s 38(1) of the Charter to give proper consideration to relevant human rights when making decisions, VLA should consider if there is any scope within existing funding constraints to expand eligibility for duty lawyer services and/or grants of legal assistance for MHT representation, to better facilitate legal representation for people who would be unable to obtain a fair hearing without it.
- Encourage the MHT to establish a protocol:
 - Requiring members to enquire of all non-attending and unrepresented persons whether they would like legal assistance and to adjourn the hearing for that purpose if they choose;
 - Setting out the circumstances in which it would decline to conduct a hearing if legal representation is unavailable and as a result a fair hearing cannot be conducted.
- Consider how legal assistance may be provided to people with hearings before the MHT who lack the capacity to formally instruct a lawyer.
- Consider whether it may be appropriate for IMHA to support people unable or unwilling to engage a lawyer to express their views to the MHT.

3B. Protecting rights in judicial contexts: mental health courts and tribunals

- Encourage the MHT to take a stronger approach to fair hearing concerns, especially regarding the late provision of reports, listings and notice provided for hearings.
- Encourage the MHT to take a more critical, inquisitorial approach to clinical evidence during hearings to obviate the need for lawyers to do so, which will reduce the level of adversarialism and perceived conflict in hearings.
- Establish a protocol with the President of the MHT for referring identified questions of law to the Supreme Court under s 197 of the *Mental Health Act 2014* (Vic).
- Explore reshaping the MHDL duty lawyer service model to allow greater hearing preparation time.
- Continue to engage with consumers/service users to validate and strengthen MHDL's approach to legal advocacy.
- Bring all relevant stakeholders, including consumers/service users, together to establish a shared understanding of what constitutes quality legal representation for MHT hearings.

3C. Protecting rights in administrative contexts: hospitals and clinicians

- Develop training and protocols regarding particular matters which IMHA should look out for and refer to MHDL for legal advocacy.
- Take steps to increase MHDL's administrative law practice, including engaging with barristers/legal experts and establishing a VLA guideline for legal assistance for judicial review matters.
- Establish and/or strengthen relationships between MHDL and clinical directors and other key staff at mental health services to discuss issues arising in practice.
- Encourage the Secretary to the Department of Health and Human Services to consult on and develop as soon as possible a Code of Practice to provide best practice, practical guidance to people and bodies exercising powers or performing functions and duties under the *Mental Health Act 2014* (Vic).
- Encourage the Chief Psychiatrist to develop practice directions or other guidelines to assist clinicians and others to correctly fulfil their new roles under the *Mental Health Act 2014* (Vic), especially regarding how to assess 'incapacity' of a patient and how to make a (lawful) compulsory treatment decision (including record-keeping requirements).
- Engage with statutory offices and organisations with oversight and regulatory functions, such as the Chief Psychiatrist, the Public Advocate, community visitors and the Mental Health Complaints Commissioner, to:
 - Learn more about each others' functions;
 - Develop protocols for passing on information about what MHDL observes in practice (to feed into both the development of standards and evaluation of particular services); and
 - Advocate for them to adopt evidenced-based and effective human rights monitoring tools.

3D. How informally detained people with disabilities obtain legal assistance

- Building on the Victorian Law Reform Commission's 2012 guardianship review, seek to engage the government to develop an appropriate response to ensure the rights of informally detained people are protected.
- Support the recommendations of the Victorian Ombudsman and the Victorian parliamentary committee inquiry to properly fund a Victorian disability advocacy scheme and ensure that the operators of that scheme, if established, understand when and how lawyers can assist.
- Develop relationships with disability service inspectors and visitors, such as community visitors, so they understand what issues lawyers can assist with and how to make appropriate referrals.
- Consider modifying VLA's 'Learning the Law' education package for special schools² to create resources suitable for special developmental school students (who have more significant disabilities), to assist them to understand when they might benefit from seeking legal assistance in the future.

4B. Setting the scope and goals of rights-based strategic advocacy

- Explore ways of strengthening the human rights culture in Victoria.
- Organise information sessions and discussions with academics and others knowledgeable about the CRPD to inform both MHDL's practice as well as that of the non-disability-specific practice areas of VLA.
- Consider introducing CRPD-modelled arguments into advocacy.
- Consider the applicability of and, where relevant, include CRPD obligations in all legislative and policy reform submissions.
- Identify and inform other advocacy organisations of VLA's willingness to support their advocacy for better CRPD compliance and assist them where possible, for instance with the sharing of ideas and information.
- Consider how best to collect and share data relating to human rights abuses.
- Advocate for laws and policies that promote positive rights, including proper investment in the NDIS and community services.
- Explore ways to advance disability rights in VLA's non-disability-specific practice areas.
- Establish a network for MHDL to collaborate with non-disability-specific sections of VLA and external agencies to better understand the intersection of the work and systemic disability rights issues, with a focus on positive rights.

² See Victoria Legal Aid, 'Learning the law' <<http://www.legalaid.vic.gov.au/about-us/community-education-and-projects/learning-law>>.

4C. Engaging in strategic advocacy

- With consumer/service user and other stakeholder input, give further consideration to how MHDL should balance individual legal services with strategic advocacy and articulate a clear rationale for the settled position.
- Consider how strategic advocacy is best coordinated and undertaken by MHDL, including who leads and evaluates the work and whether collaborating with others would be beneficial.
- Facilitate a meeting of interested members of the legal community (including private law firms, community legal centres and other human rights legal organisations) to discuss ideas and consider establishing referral and collaboration networks for strategic advocacy.
- Facilitate meetings in respect of significant legal and policy proposals and other developments as they arise to plan coordinated sector responses.
- Consider strengthening links with key journalists and research institutions.
- Strengthen and refine MHDL's data collection processes.

5A. Factors supporting high-quality and effective legal services

- Reflect on the working conditions, service model and funding of MHDL to explore opportunities for improvement.
- Develop a strategy to manage workload and reduce pressure on individual lawyers to deliver services beyond their capacity.
- Through internal and external consultation, explore alternative solutions to deal with unmet legal need.
- Consider establishing a national mental health lawyers' association and other opportunities for peer support.

5B. Efforts to regulate and improve the quality of mental health lawyers and legal services in England

- Consider regulating and/or setting standards for the provision of mental health legal services pursuant to grants of legal assistance.

Chapter 6: Looking back and looking forward

- Meet with key stakeholders and, if there is interest, establish a coalition of thought and practice leaders across the mental health and disability rights sector in Victoria to discuss the ideas arising from this fellowship and to collaborate in progressing this work.
- Establish a network of mental health and disability legal services across Australia to share practice experience, explore law reform ideas and facilitate professional development.

CHAPTER 1:

INTRODUCTION, RATIONALE AND OVERVIEW OF RESEARCH

1A. BACKGROUND AND RATIONALE FOR RESEARCH

What are human rights?

Human rights are the universal rights inherent to all human beings and to which every person is equally entitled without discrimination. Human rights are often expressed and guaranteed by law in the form of treaties and other sources of international law.

International human rights law places obligations on governments to act in certain ways or to refrain from certain acts in order to promote and protect human rights and fundamental freedoms of individuals or groups.³

Human rights may also be directly recognised and protected at a domestic level, whether through a constitutional bill of rights or legislation such as the Victorian *Charter of Human Rights and Responsibilities Act 2006* ('**Charter**'). Specific legislation may also directly implement and protect particular human rights, for example, laws that prohibit discrimination on the basis of certain characteristics or that prescribe particular processes or requirements that are considered necessary for the protection of human rights in the application of those laws.⁴

Restrictions on the human rights of persons with disabilities

Throughout history, the human rights of people with disabilities have been regularly breached on a tremendous scale. Various laws and practices, often discriminatorily applying only to people with disabilities, and whether well-meaning or otherwise, have permitted or failed to protect them from segregation, institutionalisation, social exclusion, torture, forced treatment and other medical procedures, and the denial of legal personhood and autonomy.

In the last few decades, increasing attention has been paid to the human rights of people with disabilities. Most significant at the international level was the development and adoption in 2006 of the United Nations' Convention on the Rights of Persons with Disabilities ('**CRPD**'), which has since been ratified by 159 countries including Australia. Building on the universal rights set out in other international treaties, the CRPD marked a paradigm shift from viewing people with disabilities as 'objects' of charity, medical treatment and social protection towards viewing them as 'subjects' with rights, who are 'capable of claiming those rights and making decisions for their lives based on their free and informed consent, as well as being active members of society'.⁵ The CRPD also endorsed a social model of 'disability', whereby 'disability' is not the impairment which an individual has but rather 'results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (emphasis added),⁶ which places a clear responsibility on the State to address those attitudinal and environmental barriers.

At the national level, the National Disability Insurance Scheme ('**NDIS**'), which commenced rollout in 2013, is a momentous development grounded in human rights and a recognition that people with disabilities should be able to access – and, importantly, be in control of – appropriate, timely and individualised supports that they need to live well in the community. In recent years, there have been many inquiries, reviews and frameworks at both the national⁷ and state⁸ level relating to the rights and treatment of people with disabilities, as well as numerous changes to the Victorian laws and practices relating to people with disabilities, which have increased the protection of rights.

3

United Nations Office of the High Commission of Human Rights, 'What are human rights?' <<http://www.ohchr.org/EN/Issues/Pages/WhatAreHumanRights.aspx>>.

4

For example, the rights to appear before the Mental Health Tribunal at a hearing and to be given access to documents relevant to that hearing beforehand (*Mental Health Act 2014* (Vic) ss 184(1), 191(1)) are aimed at protecting the right to a fair hearing.

5

United Nations Division for Social Policy and Development, Disability, 'Convention on the Rights of Persons with Disabilities' <<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>>.

6

CRPD Preamble (e).

7

Eg Senate Select Committee on Mental Health, Parliament of Australia, *A national approach to mental health – from crisis to community: First report* (2006); Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or coerced sterilisation of people with disabilities in Australia* (2013); Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report 124 (2014); National Mental Health Commission, *The National Review of Mental Health Programmes and Services* (NMHC, 2014); on 2 December 2015, the Australian Senate Community Affairs References Committee received a reference to inquire into and report on the indefinite detention of people with cognitive and psychiatric impairment in Australia by 30 July 2016.

8

Eg Victorian Law Reform Commission ('**VLRC**'), *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care – Report* (2003); review and reform of the *Mental Health Act 1986* (Vic) formally commenced in 2008 and went through a number of stages prior to the passage of the *Mental Health Act 2014* (Vic) – these are set out in Parliamentary Library and Information Service, Parliament of Victoria, *Mental Health Bill 2014: Research Brief* (2014); Office of the Public Advocate, *Violence against people with cognitive impairments: Report from the Advocacy/Guardianship program at the Office of the Public Advocate*, Victoria (2010); VLRC, *Guardianship: Final Report* (2012); Law Reform Committee, Parliament of Victoria, *Inquiry into Access to and Interaction with the Justice System by People with an Intellectual Disability and their Families and Carers – Final Report* (2013); VLRC, *Review of the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997: Report* (2014); Victorian Auditor-General, *Mental Health Strategies for the Justice System* (2014); Department of Health and Human Services (Victoria), *Victoria's 10 Year Mental Health Plan* (2015).

... we are regularly and soberly reminded that the rights of people with disabilities are still often disrespected or outright violated.

9

See eg Office of the Public Advocate, *Sexual assault in Supported Residential Services: Four case studies* (2012); Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – the effectiveness of statutory oversight* (2015); Family and Community Development Committee, Parliament of Victoria, *Inquiry into Abuse in Disability Services – Interim Report* (2015).

10

Carolyn Frohmader, *Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia: WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia* (Women with Disabilities Australia, 2013).

11

Office of the Chief Psychiatrist, *Chief Psychiatrist's annual report 2012-2013 and 2013-2014* (2015) 26-32.

12

Office of the Public Advocate, *Rebuilding the village: Supporting families where a parent has a disability* (2015). In launching the report, Victorian Public Advocate Colleen Pearce stated that the 'child protection system is removing children from parents with disabilities, especially cognitive disabilities or mental illnesses, at a much higher rate than parents without disabilities, as disability is assumed to be a risk to children' despite there being 'no credible evidence to support this assumption'. 'Media release: Public Advocate calls for child protection reform for parents with disabilities' (21 September 2015) <<http://www.publicadvocate.vic.gov.au/index.php/media-releases/182-public-advocate-calls-for-child-protection-reform-for-parents-with-disabilities>>.

13

Victorian Equal Opportunity and Human Rights Commission, *Beyond doubt: The experiences of people with disabilities reporting crime* (2014).

14

For instance, a treating service may not obtain formal legal authority to provide treatment to a person who is acquiescing to it or not resisting the administration of that treatment, notwithstanding the person lacks the mental capacity to provide informed consent to it.

15

Victoria performs 4.4 ECT treatments per 10,000 residents, compared to 0.75 in New Zealand and 1.8 in the UK: Kari Ann Leiknes, Lindy Jarosh von Schweder and Bjørge Høie, 'Contemporary use and practice of electro-convulsive therapy worldwide' (2012) 2(3) *Brain and Behaviour* 283.

Notwithstanding these developments, we are regularly and soberly reminded that the rights of people with disabilities are still often disrespected or outright violated. Among many other recent Australian examples, we know there is systemic sexual and other abuse of people in disability services,⁹ forced sterilisation of women with disabilities,¹⁰ numerous unexpected, unnatural or violent deaths in psychiatric units,¹¹ parents with disabilities having their children removed at disproportionately high rates,¹² and tremendous barriers for people with disabilities seeking justice through reporting crimes against them.¹³ There is sadly a long way to go before people with disabilities achieve practical equality in the realisation of their human rights.

Detention and compulsory treatment of persons with disabilities

Notions of disability and being a person with a disability have varied and contested meanings. The term 'disability' can refer to any of a wide range of conditions or impairments which, coupled with environmental, attitudinal and other barriers, may hinder a person's full and effective participation in society. However, many people resist placing mental illness under the banner of disability, preferring to see it as a distinct category or concept.

Furthermore, while some people self-identify as being a person with a disability, others have the label thrust upon them unwillingly, for instance through a disputed medical diagnosis, in what to them is a further marker of disrespect.

While acknowledging the legitimate sensitivities around language use, for the remainder of this report, I have used the term '**people with disabilities**' to refer to the subset of people whose experience was the focus of my research, that is, people with, diagnosed with or alleged to have a mental illness or intellectual, cognitive or neurological disability. In the context of this report, it does not include people with sensory or physical disabilities. Where relevant, I refer to specific disabilities.

Among current laws and practices impacting on the human rights of people with disabilities, perhaps the most significant (in terms of scope and impact) are civil laws that permit people with disabilities to be detained for compulsory treatment. This is not done as a punishment or sentence imposed by a court or because of any criminal-wrongdoing; people subject to these laws have generally not been charged with any offence nor contravened any law. Rather, the rationale is that the person may cause harm to themselves or others if they are not so detained and treated. Detention under these laws is typically (in practice at least) indefinite and will only end if and when the alleged risk has dissipated to an acceptable level or can be managed in a less restrictive way.

In this report, the term '**compulsory treatment**' refers to treatment which is administered to a person with a disability notwithstanding the person objects to it and/or has not provided informed consent. It is usually, though not always,¹⁴ administered pursuant to a formal legal power.

'**Treatment**' is much broader than the administration of medication. It includes a broad range of psychological, behavioural and other interventions aimed at remedying or alleviating symptoms and/or reducing risk, including invasive treatments like electroconvulsive treatment ('ECT').¹⁵ Some treatments may cause debilitating and serious side effects.

In Victoria, the laws permitting detention and compulsory treatment of people with disabilities are principally the *Mental Health Act 2014*, the *Disability Act 2006* and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*. Thousands of Victorians with disabilities are subjected to these laws each year.

In this report, the term ‘**closed environment**’ is used to refer to any place where a person with a disability may be formally or informally detained, except prisons. Such places include hospitals, institutions, residential disability services and group homes. They vary significantly in terms of their levels of physical security (locked doors, high walls etc), with some relying only on staff and relational security to prevent people from leaving. By their very nature, closed environments and their internal activities are typically hidden from public view.

Outside of these formal legal frameworks, a person with a disability may also be informally detained in a closed environment. Drawing on the definition of ‘detain’ in s 3(1) of the *Disability Act 2006* (Vic), a person is ‘**informally detained**’ if they are subject to constant or near-constant supervision and restrictions on their freedom of movement in the absence of any clear legal authority permitting this. While the person may be complying with or acquiescing to such supervision and restrictions in the absence of any order compelling them to, they may not be giving full, free and informed consent because:

- They lack the mental capacity to give informed consent because of, for instance, significant cognitive deficits, acute symptoms of mental illness, medication side effects or other factors; or
- They are only complying under pressure or duress because, for instance, they suspect or have been told that they would be put under a legal order and forced to comply, or would face some other consequence, if they did not.

The English Supreme Court has recently described the lack of true freedom of such ‘informal patients’.¹⁶

When people are detained – formally or informally – and subjected to compulsory treatment, many of their rights will or may be limited, including:

- The freedom to move around and be at liberty;
- The freedom to decide where and with whom to live;
- The freedom to have a family, and to have contact with family;
- The right not to be tortured or subjected to other cruel, inhuman and degrading treatment or punishment;
- The right not to be subjected to medical treatment without consent;
- The freedom to make decisions about a wide range of matters, such as daily activities and financial affairs, and to not have those decisions interfered with; and
- The right to privacy and personal autonomy.

In human rather than just legal terms, being detained and subjected to compulsory treatment is disempowering and can be extremely distressing.

Both international and domestic law recognise that limitations on certain human rights may sometimes be necessary and justifiable. In the Victorian context, limits on human rights are permissible if they can be ‘demonstrably justified’ as reasonable ‘in a free and democratic society based on human dignity, equality and freedom’, taking into account various factors.¹⁷

It has traditionally been accepted that laws allowing for the detention and treatment of persons of ‘unsound mind’ are permissible, provided certain safeguards are in place.¹⁸ At the time of its introduction to Parliament, the Victorian government stated that the *Mental Health Act 2014*, which brought in a range of new safeguards, was compatible with the Charter.¹⁹ However, whether compulsory treatment can ever be compatible with human rights, particularly if the person subjected to that treatment has the capacity to make their own decisions about treatment, is contested and the subject of much debate. This is further considered under ‘Seeking compliance with international human rights and the CRPD’ in Part 4B below.

16

Rabone & Anor v Pennine Care NHS Foundation [2012] UKSC 2, [28]–[29]:

As regards the differences between an informal psychiatric patient and one who is detained under the MHA, these are in many ways more apparent than real. It is true that the paradigm of a detained patient is one who is locked up in a secure hospital environment. But a detained patient may be in an open hospital with freedom to come and go. By contrast, an informal patient may be treated in a secure environment in circumstances where... she would, in any event, be detained if she tried to leave... Although informal patients are not “detained” and are therefore in principle free to leave hospital at any time, their “consent” to remaining in hospital may only be as a result of a fear that they will be detained. In *Principles of Mental Health Law and Policy* (2010 OUP) ed Gostin and others, the authors have written in relation to admission at para 11.03:

Since the pioneering paper by Gilboy and Schmidt in 1979, it has been recognised that a significant proportion of [informal] admissions are not ‘voluntary’ in any meaningful sense: something in the range of half of the people admitted voluntarily feel coerced into the admission; it is just that the coercion is situational, rather than using legal mechanisms.

17

These factors are: (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relationship between the limitation and its purpose; and (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve. Charter s 7(2).

18

In *Winterwerp v the Netherlands* [1979] ECHR 4, the first European Court of Human Rights case on the detention of people of ‘unsound mind’, the Court laid down the following essential safeguards:

In the Court’s opinion, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of ‘unsound mind’. The very nature of what has to be established before the competent national authority – that is, a true mental disorder – calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder (at [39]).

The Court also held that:

it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation... Mental illness may entail restricting or modifying the manner of the exercise of such a right, but it cannot justify impairing the very essence of the right. Indeed, special procedural safeguards may prove called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves (at [60]).

19

Victoria, ‘Mental Health Bill 2014: Statement of compatibility’, *Parliamentary Debates*, Legislative Assembly, 20 February 2014 (Mary Wooldridge, Minister for Health), 485–470.

Whether or not the domestic legal framework is considered to be compatible with human rights law, numerous additional factors²⁰ push against respect for human rights at a practical, operational level when a person is detained in a closed environment for compulsory treatment, which may increase and prolong restrictions on their rights in a way that is unjustified. In addition, research indicates that institutional models of care provided in closed environments increase the risk of rights abuses.²¹

'Rights frameworks are paper tigers if not supported by good enforcement machinery.'²² Therefore, rather than just statements of rights and good intentions, effective, practical safeguards are necessary to ensure that laws which permit the detention and compulsory treatment of people with disabilities are applied and operate correctly in practice, and to identify and remedy any problematic informal practices.

The role of lawyers and legal services in protecting human rights

I have predominantly used the term '**lawyer**' in this report to refer to a legal professional who is instructed by a client, advises them and conducts legal work (including court/tribunal representation) on their behalf, although 'solicitor' is more commonly used in England and 'attorney' in the US.

Lawyers and legal services are an important rights-protecting safeguard. They can minimise restrictions on human rights and protect the dignity of people with disabilities who have been detained in closed environments for compulsory treatment in a number of ways:

- Listening to the person and acting on their instructions (rather than in their perceived 'best interests') to make sure their wishes and voice are heard;
- Taking action to remove legal restrictions on rights and to increase freedoms (such as access to rehabilitation and community activities);
- Supporting the person with a disability to participate in hearings and decisions that directly affect them;
- Making sure that hearings are conducted fairly, that laws are correctly applied and that decisions permitting human rights restrictions are evidence-based;
- Helping people with disabilities to understand the rationale for any interventions and restrictions on them (which can reduce conflict and distress) and to understand what steps they can take to minimise those restrictions; and
- Checking and influencing the way laws operate at a systemic level to maximise compatibility with human rights principles.

Why am I doing this research, and why now?

I have a personal and professional interest in the protection of rights of people with disabilities who are detained in closed environments. For the last 10 years, I have been employed at Victoria Legal Aid ('**VLA**'), where I am a senior lawyer in the Mental Health and Disability Law sub-program ('**MHDL**'). By far the biggest legal service operating in this area in Victoria, MHDL provides legal services to thousands of people with disabilities each year who are detained and subjected to compulsory treatment. This includes providing in-reach legal advice services at most facilities where people with disabilities are detained, and representation before a range of courts and tribunals. VLA and MHDL's services are described further at Appendix 1. In the course of this work, I am continually confronted by how laws and practices impact on the rights of people with disabilities in closed environments.

²⁰
See Part 3C below.

²¹
Patsie Frawley and Bronwyn Naylor, 'Human rights and people with disabilities in closed environments' in Bronwyn Naylor, Julie Debeljak and Anita Mackay (eds), *Human Rights in Closed Environments* (Federation Press, 2014) 48, 67.

²²
Louise Southalan, discussing the development and rollout of Western Australia's new *Mental Health Act 2014*, in 'Involuntary Treatment: Laws, Processes and Safeguards in Western Australia and Chile' (presentation at the IALMH conference, Vienna, July 2015).

‘Rights frameworks are paper tigers if not supported by good enforcement machinery.’

– Louise Southalan

There have been significant changes in the Victorian mental health and disability legal landscape in the last few years, including:

- The enactment of the *Disability Act 2006* (Vic), which established a formal scheme for the civil detention and compulsory treatment of people with intellectual disabilities;
- The consolidation of all public funding earmarked for mental health legal services into MHDL in 2013;
- The commencement of the *Mental Health Act 2014* (Vic) and replacement of the former Mental Health Review Board with a Mental Health Tribunal in July 2014;
- Comprehensive reviews by the Victorian Law Reform Commission (‘VLRC’) of the *Guardianship and Administration Act 1986* (Vic) in 2012 and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) in 2014, which are expected to lead to significant legislative overhaul in the near future; and
- During the course of this research:
 - The commencement of VLA’s independent mental health advocacy (‘IMHA’) service in August 2015, which provides non-legal advocacy for compulsory patients; and
 - The commencement of the *Powers of Attorney Act 2014* (Vic) in September 2015.

MHDL has also undergone a significant transformation since its official formation in 2011, particularly in the last two years. We have consciously overhauled our mission and approach to service delivery as we respond to the changing legal environment. Since the redirection of existing sector funding in 2013, MHDL has also almost tripled in size to 15 dedicated lawyers. Nevertheless, we are still unable to meet the ever-increasing demand for individual legal services with our existing resources. It is particularly challenging to determine how far we can stretch our services before their quality (and staff wellbeing) become unduly compromised, and how to balance helping individual clients against undertaking more resource-intensive but potentially higher-impact strategic advocacy.

Strategic advocacy is advocacy designed to improve laws and practices that negatively impact on people in a systemic way rather than just at an individual level.

Being the primary mental health and disability legal service in Victoria creates both significant opportunities and significant responsibilities for MHDL. Particularly given the amount of change in such a short period of time, we are keen to understand how our current approach compares to practices in other jurisdictions and to explore what further changes we could make in order to better serve our core client group.

Accordingly, I undertook this Churchill Fellowship to learn how to better protect the human rights and dignity of people with disabilities, detained for compulsory treatment in closed environments, through the use of innovative legal services.

1B. OVERVIEW OF RESEARCH PROGRAM AND METHODOLOGY

I recognise that there are diverse views on the most desirable or acceptable terms to use when referring to people who access or are forced to accept mental health services. These terms include 'consumers', 'clients', 'services users', 'people with lived experience', 'users and survivors of psychiatry' and 'patients'. With no disrespect intended, I have used a mix of terms (including, simply, 'person') throughout the report, with the term often selected to provide syntactical clarity as to the relationship with another (eg lawyer and client, doctor and patient). When referring to particular interviewees, I have used their term of choice.

In this report, the term '**compulsory inpatient**' is used to refer to a person who has been formally detained for compulsory treatment under a mental health law, and the term '**mental health legal services**' refers to legal services provided to individuals who are subjected to compulsory treatment under a mental health law.

As my overall research aim was very broad, in order to maximise the utility of this work, I decided to concentrate a large part of my research on the delivery of mental health legal services to compulsory inpatients and how their rights as recognised by domestic laws are best protected in practice. I chose to focus on this because:

- More people are detained on the basis of mental illness than on the basis of a cognitive disability;
- In Victoria at least, the legal regulation and processes around the detention of people with mental illness are often more transparent than for people with cognitive and neurological disabilities, making the involvement and role of lawyers clearer and thus easier to examine; and
- The significant developments in mental health laws and legal services in Victoria in the last 18 months have opened up a dialogue which in turn creates an environment more receptive to new ideas and change.

I focused my examination of mental health legal services on two jurisdictions – New York State and England. Mental health legal services in these jurisdictions are delivered in very different ways – by a single, statutorily-mandated legal service attached to the Appellate Division of the Supreme Court in New York, and by hundreds of disparate private law firms in England. These provide an interesting contrast to each other and to the legal service model in Victoria, which falls somewhere between the two. New York's mental health legal service is 'the oldest and most comprehensive legal advocacy program for the mentally disabled in the United States',²³ and operates in an environment where individual rights are highly valued and frequently and forcefully litigated, so I was excited to learn from their advanced practice wisdom. England was also an appealing choice because its legal system – both generally and regarding compulsory mental health treatment – is very similar to Victoria's, which I hoped would make any lessons learnt more readily transferable to our context.

Like anywhere, these mental health legal services are not performed in a vacuum. Mental health legal services are significantly impacted in their work and ability to protect their clients' rights by numerous factors including:

- Any statutory mandate and powers they have;
- Levels of and any conditions on funding;
- The specific legal frameworks within which they operate;
- The practices of the courts or tribunals before whom they appear; and
- The practices, culture and attitudes of the clinicians and staff at the facilities where their clients are detained.

²³

'History of the Mental Hygiene Legal Service', 1
<http://www.courts.state.ny.us/courts/ad2/pdf/mhlsart10/MHLS_history.pdf>.

I therefore had to learn about these factors in order to place in context and properly understand the operation of the mental health legal services, and to evaluate to what extent their efforts to protect their clients' rights might be relevant or replicable in Victoria. To do this, I spoke with a range of people from different disciplines and also conducted desktop research.

Having gained some understanding of the context in which these legal services operate, I then explored how compulsory inpatients access legal assistance and how, once engaged, the legal services act and seek to influence others in judicial and administrative contexts to protect their clients' rights. I looked at how the contextual factors and forums in which they advocate either support or limit the lawyers in their endeavours, as well as how the lawyers are able to influence and impact on those factors and decision-makers in return.

To inform myself, I spoke with lawyers in each jurisdiction who provide mental health legal services and observed them providing those services, both within hospitals and in court/tribunal hearings. I also spoke with barristers, academics, clinicians, hospital staff, judges, advocacy organisations and consumers to gain a more rounded perspective. In addition, I attended a two-day training course on mental health law and practice in London (which is compulsory for lawyers seeking accreditation to appear before the Mental Health Tribunal).

Originally, I also intended to look specifically at the delivery of legal services for people with cognitive and neurological disabilities who have been formally detained for compulsory treatment. However, I discovered that:

- In New York State, the same legal service is mandated to provide essentially the same services to these people; and
- In England, people with these disabilities are predominantly formally detained under the Mental Health Act 1983 (UK), and so receive the same services from the same lawyers.

Accordingly, to avoid significant duplication, I have not reported on this separately.

Next, I looked at the delivery of individual legal services to people with disabilities who are informally detained (or who would be informally detained but for the UK 'deprivation of liberty safeguards' – see Part 3D below). My particular interest with this was understanding how they access and connect with lawyers, given the additional barriers they face.

In addition to exploring legal services conducted on behalf of individual clients, I was interested to learn whether and how lawyers in these jurisdictions engage in strategic advocacy; working on the system, not just within it. I was keen to learn how they balanced individual legal services with often resource-intensive strategic advocacy, how they selected and prioritised issues for strategic advocacy and what strategic advocacy tools they found most effective in achieving change. As well as people providing individual legal services, I spoke to a number of other organisations in these jurisdictions who engage in strategic advocacy on behalf of people with disabilities.

I also visited a number of specific organisations outside my two key jurisdictions that are well known for their strategic advocacy on behalf of people with disabilities – the Judge David L. Bazelon Center for Mental Health Law ('**Bazelon**') and the American Civil Liberties Union ('**ACLU**') in Washington DC, and the Mental Disability Advocacy Centre ('**MDAC**') in Budapest. In addition to conducting interviews with MDAC staff, I spent six weeks volunteering there (only one week of which was formally part of my Churchill fellowship), which gave me the opportunity to closely observe how the organisation operates.

While visiting strategic advocacy organisations in Washington DC and Budapest, I took the opportunity to speak with some local legal services. While I did not comprehensively look at the delivery of mental health legal services in these places, I have included some examples of interest from these jurisdictions where relevant in my report.

Finally, I attended two conferences during my travels – of the International Association of Forensic Mental Health Services ('IAFMHS') and the International Academy of Law and Mental Health ('IALMH') – to gain a broader perspective on current issues in this field.

Throughout the report, I have reflected on how my research findings compare to existing practices in Victoria and what this means for us. I also identify a number of recommendations and ideas at the end of each section of the report that I believe warrant further exploration. In the final chapter, I provide some overall reflections on the research project and discuss the next steps to turn these ideas into action.

Where only a name is provided in the body of the report or in a footnote in relation to a comment or idea, it indicates that the information was obtained through an interview, discussion or subsequent email exchange I had with that person as part of this fellowship.

The full research program, including the title and organisation of each contributor, is included at Appendix 2.

CHAPTER 2:

MENTAL HEALTH LEGAL SERVICES IN CONTEXT

Mental health legal services are not performed in a vacuum. The legal, political and social context in which they operate significantly impacts on the way in which those services are structured and delivered, which in turn significantly impacts on their work and ability to protect the human rights of their clients. I therefore had to learn about these factors in order to place in context and properly understand the operation of the mental health legal services, so that I could in turn consider to what extent their efforts to protect their clients' rights might be relevant or replicable in Victoria.

The domestic legal framework – including the degree to which rights are expressly recognised and protected as well as the specific laws relating to the detention and compulsory treatment of people with disabilities – is the most direct structural factor affecting the extent to which a lawyer can protect their clients' rights.

Other relevant contextual factors include:

- The rates of compulsory inpatient treatment;
- How compulsory inpatient treatment services are funded;
- How mental health hearings are conducted, and by whom;
- Who provides mental health legal services; and
- Whether there are other providers of legal or advocacy services to people with disabilities in the same jurisdiction.

Mental health hearings are court or tribunal hearings which are held to determine whether a person should (continue to) be subjected to compulsory treatment under a mental health law.

In this chapter, I have set out this contextual information in relation to New York State and England, which will help make sense of the more in-depth and analytical parts of this report (Chapters 3-5). For those unfamiliar with the Victorian context, I have set out the corresponding information at Appendix 3.

Jurisdiction	Population	Area
New York State	19.8 million	141,300 km ²
England	53.0 million	130,395 km ²
Victoria	5.8 million	237,629 km ²

2A. NEW YORK STATE

As part of the United States of America ('US'), New York State is bound by both state and federal laws.

General legal context and rights framework

The US provides strong constitutional protection for various rights contained in amendments 1-10 of its Constitution, which were adopted in 1791 and collectively are referred to as the Bill of Rights. Importantly, through the 14th amendment, many of these have been 'incorporated' so that they apply against the states as well. Without such 'incorporation', these amendments would only apply to breaches by the federal government.²⁴

²⁴ Michael Perlin.

New York State also has its own Constitution, article 1 of which is a Bill of Rights.²⁵

In the context of disability, it is also important to mention the following federal laws:

- The *Americans with Disabilities Act 1990* ('**ADA**'), which prohibits discrimination against people with disabilities in employment, transportation, public accommodation, communications and governmental activities; and
- The *Civil Rights of Institutionalized Persons Act 1980* ('**CRIPA**'), which did not create new rights but facilitates the protection of rights of people in state or local correctional facilities, nursing homes, mental health facilities and institutions for people with intellectual and developmental disabilities.

The US however has not agreed to be bound by key international human rights documents. While President Obama signed the CRPD in July 2009, it was not submitted to the Senate for ratification until 2012, when it fell five votes short of the two-thirds majority required. This means the CRPD is not binding on the US. The machinations behind attempts to have the CRPD ratified and the resistance by, particularly, the home school movement, were the subject of an interesting presentation at the IALMH conference by Michael Churgin. It seems that the ratification was essentially doomed to fail. Regardless, Michael said that even if it had occurred, it would have changed 'absolutely nothing' given the interpretive declarations and reservations that were drafted to accompany the proposed ratification. However, not everyone shares that view.²⁶

Similarly, the US has signed but not ratified the American Convention on Human Rights (breaches of which can be taken to the Inter-American Court of Human Rights).

Laws relating to the detention and compulsory treatment of people with mental illness: Mental Hygiene Law

New York State's *Mental Hygiene Law* is a broad statute which incorporates the organisation of the 'Department of Mental Hygiene', the *Mental Health Act*, the *Mental Retardation and Developmental Disabilities Act* and the *Alcoholism and Substance Abuse Act*.

The *Mental Health Act* part of the *Mental Hygiene Law* in turn covers the Office of Mental Health, 'hospitali[s]ation of the mentally ill' (article 9) and 'sex offenders requiring civil commitment or supervision'.

Article 9 provides people may be hospitalised as either informal, voluntary or involuntary patients:

Informal admission occurs when someone requests treatment and is admitted without a formal or written application. The patient is free to leave at any time while on such admission status.

Voluntary admission occurs when someone who is 16 or older applies in writing for admission. If the person is under 18, the parent, legal guardian, custodian or next of kin may have authority to apply on the person's behalf.

A voluntary status patient may make a written request for discharge at any time. If the patient is under age 18, the request for discharge may also be made by the person who applied for the patient's admission, by another person of equal or closer relationship, or by the Mental Hygiene Legal Service [see below].

A voluntary patient who submits a written request to leave the hospital must be released unless the director of the psychiatric cent[re] believes that the person meets the requirements for involuntary admission and therefore needs to stay. In this case, the director must apply to a judge within 72 hours for authori[s]ation to keep the patient.²⁷

The provisions relating to involuntary patients, who are the focus of much of this research, are set out in more detail below.

²⁵ Available at <<https://www.dos.ny.gov/info/constitution.htm>>.

²⁶ Michael Perlin (see also Michael L. Perlin, "'God Said to Abraham/Kill Me a Son": Why the Insanity Defense and the Incompetency Status are Compatible with and Required by the Convention on the Rights of Persons with Disabilities and Basic Principles of Therapeutic Jurisprudence' (NYLS Legal Studies Research Paper, November 2015)).

²⁷ New York State Office of Mental Health, 'Rights of Inpatients in New York State Office of Mental Health Psychiatric Centers' <https://www.omh.ny.gov/omhweb/patientrights/inpatient_rts.htm>.

Admission and retention of involuntary inpatients

Upon an application²⁸ accompanied by certificates of two examining physicians, a person alleged to be mentally ill²⁹ may be admitted to (and detained in) hospital as an involuntary patient on the basis of medical certification for up to sixty days if they are found to be 'in need of involuntary care and treatment'.³⁰ There are also provisions for emergency involuntary admission and involuntary admission under certification from a director of a community service or designated physician.

An involuntary patient can apply to the Supreme Court within sixty days of their admission for release.³¹ The hearing must be listed within five days of the request, although it can be adjourned.³² Following the hearing:

- If the court determines that the patient is not mentally ill or not in need of retention, the court must order their release.
- If the court determines that the patient 'is in need of retention', it must deny the application for release. However, the court may order the transfer of the patient to the care and custody of the patient's relatives or 'a committee of his person' if it appears that they are 'willing and able properly to care for him at some place other than a hospital'.³³

The conduct of these Supreme Court hearings is described below.

To keep the person in hospital beyond sixty days (or for more than thirty days after a failed application for release, whichever is later), if the person does not agree to be a voluntary patient, the director of the hospital must apply to the Supreme Court for a 'court retention order'.³⁴ If the person wants to be heard on that application, they must request a hearing within five days of receiving notice of the application. Otherwise, the court will consider and may grant the order on the papers. The retention order may be granted for up to six months. If the criteria continue to be met, the director can then apply for further continued retention orders, with the next one being for up to 12 months and any subsequent one for up to two years.

If a person is unhappy with the decision of the Supreme Court, they are entitled to 'obtain a rehearing and a review of the proceedings', which is heard before a different judge with a jury as the trier of fact, unless the person waives the right to trial by the jury.³⁵

Provision of treatment

The New York Office of Mental Health explains the rights of compulsory inpatients with respect to treatment:

You have a right to object to any form of care and treatment, and to appeal decisions with which you disagree.

If you object, the treatment team must make every effort to provide an alternative treatment or procedure which will be acceptable to you.

Medications or other medical treatments proposed for you must be explained to you.

If you object, you have the right to have the proposed treatment, and your objections, fully reviewed both by Office of Mental Health physicians and by a court. Except in an emergency, you cannot be treated over your objection without court authori[s]ation, and you have a right to have [a lawyer] assist you in administrative and court procedures.³⁶

These processes, and how lawyers are involved, are discussed further under 'Direct participation in 'treatment over objection' processes' in Part 3C below.

Assisted outpatient treatment

In 1999, New York State enacted legislation that provides for court-ordered assisted outpatient treatment ('AOT') for certain people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision and community-based services. This law is commonly referred to as 'Kendra's Law' after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person who was living in the community but was not receiving treatment for his mental illness at the time.³⁷

28

An application for admission may be made by any person specified in *Mental Hygiene Law* § 9.27(b), including 'a person with whom the person alleged to be mentally ill resides; the father or mother, husband or wife, brother or sister, or the child of any such person or the nearest available relative; an officer of any public or well recogni[s]ed charitable institution or agency or home, including but not limited to the superintendent of a correctional facility... in whose institution the person alleged to be mentally ill resides; the director of the hospital or of a general hospital... in which the patient is hospitali[s]ed; the director or person in charge of a facility providing care to alcoholics, or substance abusers or substance dependent persons; the director of the division for youth; a qualified psychiatrist who is either supervising the treatment of or treating such person for a mental illness in a facility licensed or operated by the office of mental health'.

29

'Mental illness means an affliction with a mental disease or mental condition which is manifest by a disorder or disturbance in behaviour, feeling, thinking or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation': *Mental Hygiene Law* § 1.03(20).

30

'In need of involuntary care and treatment means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment': *Mental Hygiene Law* § 9.01. It is distinguished from being 'in need of care and treatment' generally, which means that 'a person has a mental illness for which inpatient care and treatment in a hospital is appropriate'.

31

Mental Hygiene Law § 9.31(a).

32

Ibid § 9.31(c).

33

Ibid.

34

Ibid § 9.33.

35

Ibid § 9.35.

36

New York State Office of Mental Health, 'Rights of Inpatients', above n 27.

37

New York State Office of Mental Health, *Kendra's Law: Final report on the status of Assisted Outpatient Treatment* (2005) 35.

Any of a number of people³⁸ can file a petition with the Supreme Court in respect of a person they believe is mentally ill and in need of AOT. After a hearing, a person may be ordered to receive AOT if the court is satisfied that he or she:

- Is at least 18 years of age;
- Suffers from a mental illness;
- Is unlikely to survive in the community without supervision based on a clinical determination;
- Has a history of non-compliance with treatment for mental illness which has led to:
 - At least two hospitalisations for mental illness in the preceding three years; or
 - At least one act of serious violence towards self or others, or threats or attempts of serious physical harm to self or others, within the preceding four years (not including any period in the preceding six months in which they were hospitalised or incarcerated);
- Is, as a result of his or her mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community;
- Based on treatment history and current behavior, is in need of outpatient treatment to prevent a relapse or deterioration likely to result in serious harm to self or others; and
- Will likely benefit from AOT.³⁹

In addition, a court may not issue an AOT order unless it finds that assisted outpatient treatment is the least restrictive alternative available for the person,⁴⁰ and the court may not order treatment which is not recommended by the examining physician and included in the treatment plan.⁴¹

The initial AOT order is effective for up to six months from the date of the order.⁴² The order can be extended for successive periods of up to one year each,⁴³ but any application to extend AOT must demonstrate that the person continues to meet all of the AOT criteria. Appeals of AOT orders are taken in the same manner as rehearing and review hearings described above.

A person under an AOT order cannot be forced to receive treatment in the community.⁴⁴ Instead, if, in the clinical judgment of a physician, the assisted outpatient has failed or refused to comply with the treatment ordered by the court, efforts must be made to achieve compliance.⁴⁵ If these efforts fail, and the physician determines that the person may need involuntary admission to a hospital, the physician may request that the person be transported to a hospital, where the person may be retained for up to 72 hours for an examination to determine if inpatient care and treatment are necessary.⁴⁶ Any decision to retain the person beyond the initial 72 hours must be in accordance with the procedures for involuntary admission (described above).

Use of compulsory inpatient treatment laws

It has been very hard to find data on the rates of compulsory inpatient treatment in New York State. The state is divided into four 'departments' (geographic catchment areas), which coincide with the four branches of the state judiciary's Appellate Division. The second department (which includes Brooklyn, Queens, Long Island and the counties immediately to the north of Manhattan) is the most populous, with 9.1 million people. It has 948 inpatient beds and approximately 17,000 community residence beds.⁴⁷ In 2014, 72,036 people in the second department were committed as either voluntary or involuntary inpatients under Article 9 of the *Mental Hygiene Law*⁴⁸ (this does not include informal patients or those committed on AOT orders in the community). This translates to roughly 791 people per 100,000 people.

New York State has a rate of 15.2 AOT orders per 100,000 people.⁴⁹

Mental health hearings in the New York Supreme Court

Mental health hearings are conducted by a single judge of the New York State Supreme Court (the Supreme Court is somewhere in the middle of the hierarchy of state courts). The hearings are open to the public and are recorded.

The Supreme Court will sit at most hospitals to conduct hearings for compulsory inpatients, although inpatients from some hospitals are transported – with supervision and security – to the formal Supreme Court building for their hearings. At the hospitals, the hearing rooms are set up to resemble a courtroom, with a central bench for the judge, separate tables for the 'prosecution' and 'defence', a chair for the witness, rows of seating open to the public and official flags.

³⁸

A parent, spouse, adult sibling, or adult child of the person who is mentally ill; an adult roommate; the director of a hospital in which the person is hospitalised; the director of an organisation, agency or home in which the person resides or receives services; a psychiatrist who is either treating or supervising the person's treatment; the social services official or mental health director for the county (or City of New York) where the person is believed to be present; a parole or probation officer assigned to supervise the person; a licensed social worker or psychologist: *Mental Hygiene Law* § 9.60(e)(1).

³⁹

Mental Hygiene Law § 9.60(c).

⁴⁰

Ibid § 9.60(j)(2).

⁴¹

Ibid.

⁴²

Ibid.

⁴³

Ibid § 9.60(k).

⁴⁴

In *In re Urcuyo*, 714 NYS 2d 286 (Sup. Ct. Kings County, 2000), the Supreme Court stated that AOT patients are not involuntary patients and therefore are not subject to medication over objection. Furthermore, it rejected an argument that an AOT order, while not providing for the forcible administration of medication, nevertheless unreasonably violates the patient's right to refuse medication by threatening arrest upon non-compliance with the plan: 'the court does not agree with respondents' argument that a failure to take medication results in the summary arrest of the patient. Rather, the patient's failure to comply with the treatment plan, whose formulation the patient had the opportunity to participate in, leads to the heightened scrutiny of physicians for a 72-hour evaluation period, but only after a physician has determined that the patient may be in need of involuntary admission to a hospital': at 869-870; see also New York State Office of Mental Health, *Kendra's Law*, above n 37, 38.

⁴⁵

Mental Hygiene Law § 9.60(n); New York State Office of Mental Health, *Kendra's Law*, above n 37, 37.

⁴⁶

Mental Hygiene Law § 9.60(n).

⁴⁷

Michael Neville.

⁴⁸

Ibid.

⁴⁹

Edwina Light, 'Involuntary Psychiatric Treatment in the Community: General Practitioners and the implementation of CTOs' (presentation at the IALMH conference, Vienna, July 2015).

‘Any person hospitali[s]ed against his/her will is entitled to watchful protection of his/her rights, because he/she is a citizen first and a mental patient second.’

– *Special Committee to Study Commitment Procedures of the Association of the Bar of New York City, 1962*

Anecdotally, around 90% of compulsory inpatients attend their hearings, although there are lower rates of participation by compulsory outpatients (anecdotally around 60%), as their hearings take place in the Supreme Court building rather than in the hospital or community mental health service.

A lawyer from the Attorney-General’s office represents the state hospitals and prosecutes the cases. However, private hospitals will be represented by private counsel and public city hospitals by the New York City Health and Hospitals Corporation. The onus is squarely on the State to adduce sufficient evidence, and the rules of evidence (including the exclusion of hearsay) apply.

Prior to most hearings, negotiation takes place between the lawyers and doctors over things like the length of an order.⁵⁰ Lawyers negotiate directly with doctors and treating team. However, even where a negotiated settlement is reached between the parties on the ‘steps’ of court, the State still calls the psychiatrist to the stand to give evidence under oath/affirmation and leads them through their evidence.

In each hearing, the complete clinical file is tendered (pursuant to business rule exception to hearsay) and admitted into evidence (subject to any hearsay). However, in the hearings I observed, the judge did not appear to look at or refer to the file and instead acted on the oral testimony. In some hearings, at the conclusion of the State’s evidence-in-chief and prior to opening the ‘defence’ case, the patient’s lawyer may make submissions that there is no case to answer because the State has not adduced sufficient evidence to establish that the criteria are met.

If the judge decides that there is a case to answer, the patient’s lawyer may – or may not – call their client to give evidence. This is a forensic decision as the hospital seeking to detain and treat them bears the burden of proof. Furthermore, calling them to give evidence exposes them to cross-examination (although it varies as to how much the hospital’s representative is minded to do this), plus the judge will then often ask them questions. The court cannot otherwise compel a patient to speak and so lawyers may advise their clients that it is in their best legal interests to not testify at their hearing.⁵¹ However, most judges that hear these cases are loathe to discharge someone they have not heard evidence from so, in practice, patients are often called to give evidence if the judge has decided that there is a case to answer. If called, they remain seated next to their lawyer and give their evidence from there rather than in the witness box.

Having no fellow decision-makers to deliberate with, the judge provides their decision immediately upon conclusion of the legal submissions.

Mental health legal service provider: Mental Hygiene Legal Service

Mental health legal services in New York State are provided by the Mental Hygiene Legal Service (‘MHLS’), which is the ‘oldest legal advocacy program for the institutionalized mentally disabled in the [US]’.⁵²

In 1962, the Special Committee to Study Commitment Procedures of the Association of the Bar of New York City declared that ‘[a]ny person hospitali[s]ed against his/her will is entitled to watchful protection of his/her rights, because he/she is a citizen first and a mental patient second’ and ‘recommended the creation of a new statewide agency, independent of the hospitals and the then Department of Mental Hygiene, that would be responsible to the courts handling mental hospital admissions’.⁵³

⁵⁰ Sara Rollyson.

⁵¹ Alison Lynch (whose direct knowledge of this practice comes from her time working as a mental health lawyer in New Jersey, but who said that anecdotally it seems to her like a universal experience).

⁵² ‘History of the Mental Hygiene Legal Service’, above n 23, 1.

⁵³ Ibid (citation omitted).

‘We usually have someone at the hospital, at least at Kings County, almost every day of the week...’

– Sara Rollyson, MHLC, New York

Between its establishment in 1964 and 1986, the MHLS (then called the Mental Health Information Service) ‘functioned primarily in an informational and ombudsman capacity [but has since] evolved into a dedicated legal advocacy program providing a broad range of protective legal services and assistance to mentally disabled persons under the care or jurisdiction of State-operated or licensed facilities’.⁵⁴

Scope of functions

The MHLS was established and derives its powers and mandate through Article 47 of the *Mental Hygiene Law*. Article 47.01 provides that the MHLS ‘shall provide legal assistance to patients or residents of a facility⁵⁵... and to persons alleged to be in need of care and treatment in such facilities or places’.

The MHLS is mandated by § 47.03 of the *Mental Hygiene Law* to perform the following key functions and duties in relation to compulsory inpatients:

- To study and review the admission and retention of all patients, including their willingness to remain under that legal status;
- To inform patients and, ‘in proper cases, others interested in the patients’ welfare’ of procedures for admission and retention and of the patients’ rights to have a judicial hearing and review, to be represented by legal counsel and to seek independent medical opinion; and
- To provide legal services and assistance to patients and their families in relation to their admission, retention, and care and treatment.

To support this work, the MHLS is entitled ‘to be granted access at any and all times to any facility or place or part thereof... and to all books, records and data pertaining to any such facility or place deemed necessary for carrying out its functions, powers and duties’ and to require from employees any information deemed necessary for those functions.⁵⁶ The facilities are also required to provide notice of various matters to the MHLS.

In addition to its functions in relation to compulsory inpatients, the MHLS is mandated to perform many other roles:

- To fulfill the same functions as above in relation to ‘residents’ detained under the *Mental Retardation and Developmental Disabilities Act*;⁵⁷
- To fulfill various functions in relation to patients and residents who have been informally or voluntarily admitted;⁵⁸
- To represent all people subject to applications for AOT orders;⁵⁹
- To represent all people subject to guardianship;
- To represent all forensic patients;
- To provide legal assistance, services and representation to sex offenders requiring civil commitment or supervision post-sentence;⁶⁰ and
- To ‘initiate and take any legal action deemed necessary to safeguard the right of any patient or resident to protection from abuse or mistreatment, which may include investigation into any such allegations of abuse or mistreatment’.⁶¹

⁵⁴ Supreme Court of the State of New York Appellate Division, Second Judicial Department, ‘Mental Hygiene Legal Service’ <https://www.nycourts.gov/courts/ad2/mhls_mainpage.shtml>.

⁵⁵ ‘Facility’ means ‘any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution, or building, except that in the case of a hospital as defined in article twenty-eight of the public health law it shall mean only a ward, wing, unit, or part thereof which is operated for the purpose of providing services for the mentally disabled’. ‘Mental disability’ means ‘mental illness, mental retardation, developmental disability, alcoholism, substance dependence, or chemical dependence’ and a ‘mentally disabled person’ is one who has a mental disability: *Mental Hygiene Law* § 1.03.

⁵⁶ *Mental Hygiene Law* § 47.03(d).

⁵⁷ Ibid § 47.03; this work is governed by the *Mental Retardation and Developmental Disabilities Act*, which is Part C of the *Mental Hygiene Law*.

⁵⁸ See Part 3D below.

⁵⁹ *Mental Hygiene Law* § 9.60(g) establishes a right to representation ‘at all stages of a proceeding’ in relation to AOT and § 47.03(c) places the duty on the MHLS to provide that representation.

⁶⁰ Ibid § 47.03(f); this work is governed by Article 10 of the *Mental Hygiene Law*.

⁶¹ Ibid § 47.03(e).

Practical and operational arrangements

The MHLS is part of the Appellate Division of the Supreme Court and its budget is set by the court. At a day-to-day level, principal attorney Sara Rollyson did not think that the MHLS being part of the court was either useful, limiting or had any real impact on their status: 'it's just how we exist'. She did note they were 'kind of an anomaly... We are the only court attorneys that actually have clients'.

As noted above, New York State is divided into four judicial departments and there is an MHLS connected to each of these departments. Each MHLS department has multiple offices within their catchment area.

Some MHLS offices are actually located within hospitals (for instance, an office of the First Department MHLS is located on the ninth floor of the Bronx Psychiatric Center ('BPC'), although staff from that office also provide services at a number of other hospitals), while other MHLS offices are separately located. The Brooklyn branch of the Second Department MHLS used to be based at Kings County Hospital. While they maintain a 'tiny' satellite office within the hospital, they now have permanent offices near the court:

Personally I liked being at the hospital but I am the minority there because our facilities here are much nicer and more professional. We didn't have conference rooms and... my office was an old bathroom and it used to snow in my office in winter, like on my computer. It wasn't the best facilities there so this is definitely better...

I liked being able to rush [to the ward] immediately if there was some issue but even now we really don't have that much of a problem. We usually have someone at the hospital, at least at Kings County, almost every day of the week so... if there is an emergency we can get there. It's not that far.⁶²

Other providers of mental health and disability legal services

While the MHLS is essentially the sole provider of legal services for people wishing to challenge their detention and compulsory treatment under the *Mental Hygiene Law*, there are many other legal services and organisations in New York which also work to protect the rights of people with disabilities, either individually or as a class.

Some of these organisations and the work they do are specifically discussed under '4C. Engaging in strategic advocacy' and Appendix 7 below.

⁶²
Sara Rollyson.

2B. ENGLAND

England is a country within the United Kingdom ('UK'), which in turn is a member state of the European Union ('EU').

General legal context and rights framework

When I was in England, making mainstream news was the 800th birthday of the Magna Carta, austerity measures including cuts to legal aid funding, and the conservative government's proposal to withdraw from the EU and the jurisdiction of the European Court of Human Rights ('ECtHR').

England has no constitution, but the common law recognises and protects various rights.

The UK ratified the European Convention on Human Rights ('ECHR') in 1951, but it was not until the *Human Rights Act 1998* (UK) that the ECHR rights were directly incorporated into domestic law. This means that breaches can now be challenged in English courts, with any disputes ultimately taken to the ECtHR.

The UK has ratified the CRPD and its optional protocol, which allows an individual to petition the United Nations Committee on the Rights of Persons with Disabilities ('CRPD Committee') claiming that the UK has breached their Convention rights. An inquiry will be conducted if the CRPD Committee receives reliable information indicating grave or systematic violations.

Laws relating to the detention and compulsory treatment of people with mental illness

The *Mental Health Act 1983* (UK) ('MHA') sets out the process and standards for the admission, detention and treatment of 'mentally disordered patients'.⁶³ 'Mental disorder' is very broadly defined to mean 'any disorder or disability of the mind',⁶⁴ which means that this law also covers people with any of a range of cognitive and neurological disabilities even in the absence of a co-occurring mental illness. However, having a 'learning disability'⁶⁵ will not bring the person within most powers under the MHA 'unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his [or her] part'.⁶⁶ Several thousand people with learning disabilities are detained under the MHA each year,⁶⁷ with an average length of stay of 547 days.⁶⁸

Admission and detention for treatment

The main provisions relating to civil detention under the MHA are ss 2 and 3. While the criteria for detention under either s 2 or s 3 must both 'be applied in a context that requires detention to be strictly justified', the criteria for detention under s 3 are necessarily more demanding.⁶⁹

A person ('section 2 patient') can be admitted to hospital for assessment (and treatment following that assessment) for up to 28 days following an application by an 'approved mental health professional' ('AMHP'),⁷⁰ which is supported by the recommendations of two doctors who each consider that the following criteria apply:

- (a) 'he [or she] is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- (b) 'he [or she] ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons'.⁷¹

Upon a similar application, a person ('section 3 patient') can be admitted to hospital for long-term treatment if:

- (a) 'he [or she] is suffering from a mental disorder of a nature or degree which makes it appropriate for him [or her] to receive medical treatment in a hospital; and
- (b) '[repealed]'⁷²
- (c) 'it is necessary for the health or safety of the patient or for the protection of other persons that he [or she] should receive such treatment and it cannot be provided unless he [or she] is detained under this section; and
- (d) 'appropriate medical treatment is available for him [or her]'.⁷³

⁶³ *Mental Health Act 1983* (UK) s 1(1).

⁶⁴ Ibid s 1(2). Note that references to 'hospital' in the compulsory admission to hospital part of the *Mental Health Act 1983* (UK) also include 'registered establishments' (which are independent hospitals registered under Part II of the *Care Standards Act 2000* in which treatment and/or nursing are provided for persons liable to be detained under this Act): s 34.

⁶⁵ This is defined to mean 'a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning': *Mental Health Act 1983* (UK) s 1(4). The term 'learning disability' is commonly used in England instead of intellectual disability.

⁶⁶ *Mental Health Act 1983* (UK) s 1(2A).

⁶⁷ Lucy Series, referencing the 2014 Learning Disability Census, below n 68.

⁶⁸ Health and Social Care Information Centre, Community and Mental Health Team, *Learning Disability Census Report: England 30 September 2014* (2015).

⁶⁹ *MS v North East London Foundation Trust* [2013] UKUT 92 (AAC).

⁷⁰ An AMHP is a person, other than a registered medical practitioner, appointed by a local social services authority under s 114 of the *Mental Health Act 1983* (UK). Before approving a person as an AMHP, the authority must be satisfied that the person 'has appropriate competence in dealing with persons who are suffering from mental disorder': s 114(3). They are typically social workers, nurses, occupational therapists or psychologists who have undergone specialist training. The AMHP role replaced the previous 'approved social worker' role in 2008.

⁷¹ *Mental Health Act 1983* (UK) s 2(2).

⁷² This criterion, repealed in 2008, was known as the 'treatability test': 'In the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration of his [or her] condition'. It was effectively replaced by an 'appropriate treatment test' in s 3(2)(d).

⁷³ *Mental Health Act 1983* (UK) s 3(2).

... the criteria for detention under either s 2 or s 3 must both 'be applied in a context that requires detention to be strictly justified'.

– *MS v North East London Foundation Trust* [2013] UKUT 92 (AAC)

Before making an application for admission under s 3, the AMHP must consult with whoever appears to be the nearest relative of the person – unless 'such consultation is not reasonably practicable or would involve unreasonable delay' – and the admission cannot go ahead of the nearest relative objects.⁷⁴ However, if the nearest relative is perceived to be unreasonable, the service may apply for them to be displaced as the nearest relative.⁷⁵

Provision of treatment

The MHA defines 'medical treatment' broadly to include nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.⁷⁶ The purpose of the treatment must be 'to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations'.⁷⁷

Where a patient is detained under s 2 or s 3, the patient's consent is not required for any medical treatment given to them for their mental disorder 'if the treatment is given by or under the direction of the approved clinician in charge of the treatment'.⁷⁸ However, after three months of treatment, a 'second opinion appointed doctor' ('SOAD') is required.⁷⁹ For treatment to be lawful beyond this point, either:

- The patient must be consenting (and the authorised clinician or SOAD certifies in writing that the person is consenting and has the capacity to consent); or
- The SOAD certifies that it is appropriate for the treatment to be given despite either the patient refusing to consent or lacking the capacity to do so.⁸⁰

The Care Quality Commission⁸¹ ('CQC') is responsible for providing the SOAD service, although the 120 psychiatrists on the SOAD panel operate independently of the CQC.⁸² In 2014-2015, 11,610 compulsory inpatients were assessed by a SOAD in relation to their medication.⁸³ In 30% of cases, the proposed treatment plan was changed following the SOAD assessment,⁸⁴ often because the person was being prescribed medication above the recommended dosage.⁸⁵

ECT is separately regulated to other treatments. If an adult patient does not provide informed consent to ECT, they can only be given ECT if a SOAD certifies that: they lack capacity, it is appropriate for the treatment to be given, and the treatment would not conflict with an advance decision or a decision of certain others with decision-making authority for the person.⁸⁶ In 2014-2015, there were 1632 SOAD visits for proposed ECT,⁸⁷ and the proposed ECT plan was changed in 21% of cases following the SOAD assessment.⁸⁸

However, the SOAD safeguards do not apply in respect of treatment:

- 'which is immediately necessary to save the patient's life;
- 'which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- 'which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- 'which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others'.⁸⁹

Where the treatment falls within (a) or (b), the ECT SOAD safeguards do not apply either.⁹⁰

Furthermore, if the authority to provide treatment expires (for instance, the patient loses capacity or withdraws their consent, or the three months have elapsed before the SOAD has provided an opinion), the approved clinician can continue administering the treatment if they consider that discontinuing it 'would cause serious suffering to the patient'.⁹¹

⁷⁴ MHLA, *Law Society accreditation scheme training coursebook* (2015) 60.

⁷⁵ *Mental Health Act 1983* (UK) s 29(3)(c).

⁷⁶ *Ibid* s 145(1).

⁷⁷ *Ibid* s 145(4).

⁷⁸ *Ibid* s 63.

⁷⁹ *Ibid* s 58.

⁸⁰ *Ibid* s 58(3).

⁸¹ See 'Care Quality Commission' in Part 3C below.

⁸² CQC, *Monitoring the Mental Health Act in 2013/14* (2015) 23.

⁸³ CQC, *Monitoring the Mental Health Act in 2014/15* (2015) 19.

⁸⁴ *Ibid*.

⁸⁵ CQC, *Monitoring the Mental Health Act in 2013/14*, above n 82, 24.

⁸⁶ *Mental Health Act 1983* (UK) s 58A(5).

⁸⁷ CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 19.

⁸⁸ *Ibid*.

⁸⁹ *Mental Health Act 1983* (UK) s 62(1).

⁹⁰ *Ibid* s 62(1A).

⁹¹ *Ibid* s 62(2).

When and how will detention end?

Depending on the circumstances, detention for compulsory treatment may be brought to an end by the 'responsible clinician',⁹² the Mental Health Tribunal ('MHT'), hospital managers or the person's nearest relative. The processes through which this may occur are set out in Table 1 below.

The MHT, and conduct of MHT hearings, are described under a separate heading, 'Mental health hearings before the English Mental Health Tribunal', below.

Table 1: When and how will detention for compulsory treatment end?⁹³

	Section 2 patients	Section 3 patients
Duration of order	Up to 28 days	<ul style="list-style-type: none"> Indefinite, although must be renewed periodically by the responsible clinician and another professional (at the end of the first six months, it may be renewed for six months and thereafter for further periods of 12 months)
How may a person be discharged?	As for section 3 patients	<ul style="list-style-type: none"> If any of the following are not satisfied the criteria apply: <ul style="list-style-type: none"> Responsible clinician MHT (see below) 'Hospital managers' (see below) Irrespective of consideration of the criteria, by order of their nearest relative upon 72 hours notice (during which time the responsible clinician may issue a barring notice if they believe the person is likely to act in a manner dangerous to themselves or others if discharged).
When can the person apply to the MHT for a hearing?	During the first 14 days only	<ul style="list-style-type: none"> Once during the first six-month period, once during the subsequent six-month period, and once during each annual period thereafter The person's nearest relative may also apply if the responsible clinician barred their discharge order on the basis of dangerousness
When may/must a 'reference' be made to the MHT to conduct a hearing?	By Secretary of State for Health – discretionary (patients may ask the Secretary to make reference)	<ul style="list-style-type: none"> By Secretary of State for Health – discretionary By hospital managers – mandatory: <ul style="list-style-type: none"> Upon the expiry of a six-month period after a person was detained (even if they have subsequently been discharged on a CTO), unless an exception applies If more than three years have elapsed since the case was considered by the MHT
Types of discharge	As for section 3 patients, except they <i>cannot</i> be discharged on a community treatment order ('CTO')	<ul style="list-style-type: none"> Immediate, unconditional discharge Delayed to a future date (by the MHT only) On a CTO (see below) NB The person may choose to remain in hospital voluntarily after being discharged.

⁹² The 'responsible clinician' is 'the approved clinician with overall responsibility for the patient's case': *ibid* s 34(1)(a).

⁹³ Table adapted from MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 24 and 28-29

Appeals against MHT decisions

Judicial review is an administrative law procedure in which a court reviews the lawfulness of a decision, act or omission of a tribunal, public authority or person exercising administrative power. In Victoria, judicial review cases are heard in the Supreme Court.

Prior to 2007, the only way to challenge a decision of the MHT was to seek judicial review in the High Court. Since 2007, following the restructure of the tribunal system, challenges to MHT decisions are now taken to the 'Upper Tribunal (Administrative Appeals Chamber)' ('**Upper Tribunal**').

[Judicial review] was often a slow process and the new structures were meant to bring about speed. There is now a review procedure where a judge of the First-tier Tribunal can set aside a decision if there is a clear error of law and can grant leave to appeal to the Upper Tribunal. The Upper Tribunal now hears appeals from both the [MHT in England] and the Mental Health Review Tribunal for Wales. The Upper Tribunal can also grant leave to appeal and can treat an application as a judicial review.⁹⁴

Hospital managers' hearings

The number and frequency of applications which a compulsory patient can make to the MHT is restricted. However, patients can request a 'hospital managers' hearing' at any time. Hospital managers' hearings are also required to be initiated in certain circumstances.⁹⁵ Hospital managers are volunteers of varying backgrounds appointed by hospital trusts specifically to conduct hearings. These are similar to MHT hearings in that there are almost always three people on the panel (although none have 'legal' or 'medical' status), they receive written medical, social circumstances and nursing reports as well as oral evidence from the authors, and they have a power to discharge patients upon consideration of the same criteria.⁹⁶

Hospital managers' hearings are discussed further in Part 3C below.

Community treatment orders

CTOs were introduced in England in 2008 and were intended to cater for 'revolving door' patients who come in and out of hospital frequently.⁹⁷ They may only be made in respect of section 3 patient, and cannot be made in respect of a section 2 patient, an informal patient or an outpatient.

In order to make a CTO, the responsible clinician must be satisfied that the following criteria apply:

- (a) 'the patient is suffering from mental disorder of a nature or degree which makes it appropriate for [the patient] to receive medical treatment;
- (b) 'it is necessary for [the patient's] health or safety or for the protection of other persons that he [or she] should receive such treatment;
- (c) 'subject to [the patient] being liable to be recalled as mentioned in paragraph (d) below, such treatment can be provided without his [or her] continuing to be detained in a hospital;
- (d) 'it is necessary that the responsible clinician should be able to exercise the power... to recall the patient to hospital; and
- (e) 'appropriate medical treatment is available for [the patient].'⁹⁸

A CTO can be subject to any discretionary conditions that the responsible clinician and AMHP agree are necessary or appropriate to ensure the person receives medical treatment, to prevent risk of harm to the person's health or safety, or to protect others.⁹⁹ Once the CTO is made, the underlying authority for detention lies dormant for the duration of the CTO but is resurrected if the CTO is revoked.¹⁰⁰

The responsible clinician may recall a person on a CTO to hospital for up to 72 hours if the person breaches a mandatory condition of the CTO, or if the responsible clinician is of the opinion that the person requires medical treatment in hospital for their mental disorder *and* there would be a risk of harm to the health or safety of the person or others if they were not recalled to hospital.¹⁰¹ Once recalled, the CTO can then be revoked, which results in the person continuing to be detained in hospital, or they can be released back on their CTO.

⁹⁴ Sarah Johnson, Sophy Miles and Claire Royston, *Mental Health Tribunal Handbook* (Legal Action Group, 2015) 86.

⁹⁵ Department of Health (UK), *Mental Health Act 1983: Code of Practice* (2015) [38.12].

⁹⁶ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 43.

⁹⁷ *Ibid* 38.

⁹⁸ *Mental Health Act 1983* (UK) s 17A(5).

⁹⁹ *Ibid* s 17B(2).

¹⁰⁰ *Ibid* ss 17D, 17G; MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 40.

¹⁰¹ *Mental Health Act 1983* (UK) s 17E.

Once a CTO begins, only the responsible clinician has the power to vary, add or remove conditions; the MHT has no power of variation.¹⁰²

The provisions regarding the administration of treatment to people on CTOs are ‘notoriously complicated’.¹⁰³

Use of compulsory inpatient treatment laws

As at 31 March 2015, there were 25,117 people subject to orders under the MHA, a 6.7% increase on the previous reporting period and a 20% increase since 2011.¹⁰⁴ Of these, 19,656 people were detained in hospital.¹⁰⁵

In the 12 months to 31 March 2015, the MHA was used on 58,399 occasions to detain people in hospital on orders longer than 72 hours, which is 9.8% more than during the 2013-14 reporting period and 42.9% more than 2003-04.¹⁰⁶ This equates to around 99 detentions per 100,000 population.¹⁰⁷ The increase (at least over the last five years) reflects a rise in the number of section 2 patient detentions (40,063 in 2014/15), as the number of section 3 patient detentions (14,644) remained steady during this time.¹⁰⁸ However, there has been a 63% increase in the number of section 2 patients being converted to section 3 patients (ie being subjected to longer-term detention orders) over the last five years.¹⁰⁹

Unlike Victoria, people can be detained in private hospitals under mental health laws in England. As at 31 March 2015, 27.7% of people detained under the MHA were detained by independent (non-National Health Service, ‘NHS’) providers, reflecting a year-on-year increase from 24% in 2011.¹¹⁰ Due to bed shortages in the NHS system, there has been a dramatic increase in the number of private hospital beds being bought by the NHS,¹¹¹ and people are increasingly being admitted to hospitals hundreds of kilometres away from their homes and communities.¹¹²

While increasing, CTOs are still used at much lower rates than MHA orders for detention, at only 8.1 CTOs per 100,000 people.¹¹³ During 2014-15, 4564 new CTOs were issued and, as at 31 March 2015, 5,461 people were being compulsorily treated in the community on CTOs.¹¹⁴ This was 32% more than at the end of 2008-09, the year CTOs were introduced.¹¹⁵ In 2014-15, 1427 people were detained following revocation of their CTO.¹¹⁶

Mental health hearings before the English Mental Health Tribunal

While they use the same law, there are separate tribunals in England and Wales which conduct hearings under the MHA. The formal name of the tribunal in England is the ‘First-tier Tribunal (Health, Education and Social Care Chamber) (Mental Health)’ (‘MHT’). In 2014-2015, 28,892 applications were made to the MHT in respect of compulsory inpatients, which resulted in 17,635 hearings (almost 8000 people were discharged prior to the hearing occurring).¹¹⁷ MHT hearings are conducted at over 600 locations across the country.¹¹⁸ The tribunal in Wales is called the Mental Health Review Tribunal. While it functions in a very similar fashion to the English MHT,¹¹⁹ I have confined my comments in this report to the English jurisdiction which I observed firsthand.

The powers, duties and procedures of the MHT are contained within the MHA and the *Tribunal Procedure (First-tier tribunal) (Health, Education and Social Care Chamber) Rules 2008* (UK), which are very prescriptive.

To hear cases, the MHT sits as a panel of three: a medical member, a ‘specialist lay member’ and a legal chairperson (who is a person appointed to the MHT as a ‘judge’). The MHT only lists up to two oral hearings per day – a morning and an afternoon hearing.¹²⁰ The actual hearing time is on average an hour or a bit over an hour, but that does not include the time spent by MHT members preparing for the hearing, deliberating or delivering their decision.

Up until April 2014, it was mandatory for ‘an appropriate member’ of the MHT (in practice, the medical member) to conduct a separate medical examination of every person prior to their hearing ‘to form an opinion of the patient’s mental condition’.¹²¹ Under the amended rules, a prior examination will only occur:

- In section 2 patient matters (within the first 28 days of admission), ‘unless the Tribunal is satisfied that the patient does not want such an examination’;
- In any other matter where the patient or their representative has requested this in writing at least 14 days before the hearing; and
- If the Tribunal has directed an examination.¹²²

¹⁰² MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 40.

¹⁰³ Ibid 19.

¹⁰⁴ Health and Social Care Information Centre, Community and Mental Health Team, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment: Annual Statistics, 2014/15* (2015) 10.

¹⁰⁵ Ibid.

¹⁰⁶ Ibid 12.

¹⁰⁷ In 2013-14, the rate was 98.7 per 100,000 population: Health and Social Care Information Centre, Community and Mental Health Team, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, Annual report, England, 2013-2014* (2014) 18.

¹⁰⁸ Health and Social Care Information Centre, *Annual Statistics, 2014/15*, above n 104, 13. Only 1930 of the 58,399 detentions related to people in criminal justice proceedings or under sentence. For specific figures, see Reference Table 1, below n 116.

¹⁰⁹ Health and Social Care Information Centre, *Annual Statistics, 2014/15*, above n 104, 14.

¹¹⁰ Ibid 11.

¹¹¹ Phil O’Hare and Gavin Davidson, ‘Comparison of the use of mental health and mental capacity law across jurisdictions in the UK and Ireland’ (presentation at the IALMH conference, Vienna, July 2015).

¹¹² CQC, *Monitoring the Mental Health Act in 2013/14*, above n 82, 46.

¹¹³ Light, above n 49.

¹¹⁴ Health and Social Care Information Centre, *Annual Statistics, 2014/15*, above n 104, 20.

¹¹⁵ Health and Social Care Information Centre, *Annual report, 2013-2014*, above n 107, 6.

¹¹⁶ Health and Social Care Information Centre, Community and Mental Health Team, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment: Annual Figures, England, 2014/15 - Reference Tables, Table 1* (2015).

¹¹⁷ CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 68.

¹¹⁸ Amar Shah, ‘Is the Mental Health Review Tribunal inherently unfair to patients?’ (2010) 17(1) *Psychiatry, Psychology and Law* 25, 25.

¹¹⁹ Alex Ruck Keene.

Due to bed shortages in the NHS system... people are increasingly being admitted to hospitals hundreds of kilometres away from their homes and communities.

The MHT 'should' direct a medical examination if the patient fails to attend their hearing, and in fact is prohibited from proceeding with a hearing that the patient has failed to attend if such an examination has not been carried out unless satisfied that the examination is 'impractical or unnecessary'.¹²³

Having conducted the examination, which usually takes place on a separate day to the hearing, the medical member will discuss their findings with the MHT panel in private, during which they are permitted to express not only facts but also a preliminary opinion on the person's mental condition and the statutory criteria.¹²⁴ At the commencement of the hearing, either the medical member or the judge will summarise the examination and finding for the parties present.

In addition to requiring a responsible clinician's report, a nursing report and a social circumstances report, the MHT expects the author of each report to attend the hearing to speak to their report and be cross-examined. After each report author presents their report, each MHT member questions them in turn, before the person's lawyer cross-examines them.

After legal submissions, the MHT will stand down to deliberate and will call the parties back into the room to give its decision and reasons. The MHT must discharge the person if it is not satisfied that the statutory criteria (set out above) are met.¹²⁵ The MHT also has a discretionary power to discharge a patient even if it is satisfied that these criteria are met.¹²⁶ This rarely exercised power is 'to be used in exceptional circumstances only', for instance, a patient being discharged into the care of relatives overseas.¹²⁷ The following table sets out the outcomes of MHT hearings for section 2 and section 3 patients respectively in 2014-2015.

Table 2: Outcomes of MHT hearings for civil compulsory inpatients 2014-2015¹²⁸

Outcomes of hearings	Section 2 patients	Section 3 patients
Discharged (total)	690 (12.8%)	530 (7.8%)
<i>Immediate discharge</i>	485 (9.0%)	370 (5.4%)
<i>Delayed discharge</i>	204 (3.8%)	160 (2.3%)
Not discharged	4710 (87.2%)	6287 (92.2%)

The MHT must provide written reasons in respect of every decision – within three days for section 2 patient matters and within seven days for all other matters.¹²⁹

Where the MHT does not discharge a person,¹³⁰ it has a statutory power to:

- Recommend that they be granted leave of absence or transferred to another hospital or into guardianship with a view to facilitating their discharge on a future date; and
- Further consider their case in the event the recommendation is not complied with.¹³¹

Upon making recommendations, the MHT will usually set a date at which they will consider the need to reconvene to determine whether the recommendation has been complied with. Nevertheless, MHT recommendations are ultimately not legally enforceable.

MHT recommendations are discussed further in Part 3C below.

Mental health legal service providers: contracted private law firms

There is no statutory agency or state-run legal service to provide legal services for people being compulsorily treated under the MHA. Instead, the Legal Aid Agency periodically awards contracts to private law firms to provide mental health legal services, which cover matters under the *Mental Capacity Act 2005* (UK) ('MCA') as well as the MHA.

¹²⁰

Oral hearings are usually listed at 10:30pm or 2:30pm, although the MHT also conducts some 'paper' CTO hearings: Jonathan Wilson. Such paper hearings can only occur where the hospital has referred the case to the MHT for review, the person is on a CTO and is aged 18 or over, they (or their representative) state in writing that they do not want to attend or be represented and the MHT is satisfied they have the capacity to decide whether or not to make this decision: *Tribunal Procedure (First-tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008* (UK) r 35(3) ('Tribunal Procedure (First-tier Tribunal) Rules 2008 (UK)').

¹²¹

Ibid r 34 (since amended).

¹²²

Ibid r 34 (current).

¹²³

Ibid r 39(2); First-Tier Tribunal, Health Education And Social Care Chamber, *Practice Direction and Guidance: Medical Examinations*, 11 March 2014, 2.

¹²⁴

R (RD) v MHRT [2007] EWHC 781 (Admin).

¹²⁵

Mental Health Act 1983 (UK) s 72(1).

¹²⁶

Ibid.

¹²⁷

GA v Betsi Gadwaladr University Local Health Board [2013] UKUT 280 (AAC), in MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 26.

¹²⁸

CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 68.

¹²⁹

Tribunal Procedure (First-tier Tribunal) Rules 2008 (UK) r 41.

¹³⁰

Other than in 'restricted' cases. Restrictions may only be imposed on criminal orders (either based on a court decision or a transfer from prison to a psychiatric hospital), not civil detention orders: MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 5.

¹³¹

Mental Health Act 1983 (UK) s 72(3).

The Legal Aid Agency

The Legal Aid Agency is an executive agency of the Ministry of Justice. It was established in 2013 to replace the Legal Services Commission, which had been a non-departmental public body. Its role is 'to commission and administer legal aid services in England and Wales, taking account of the relevant provisions of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012* (UK) and the policy and strategy set by ministers and the [Ministry of Justice]'.¹³² It commissions services through contracts and does not employ in-house or salaried lawyers for direct legal service provision.

Over 300 firms across England and Wales – an area smaller than the size of Victoria – have contracts with the Legal Aid Agency to undertake mental health law work,¹³³ a figure which the Legal Aid Agency reports is small compared with the number of firms contracted to provide services in other areas of law.¹³⁴

The scope of work undertaken by these firms is squarely determined by what the contract and legal aid regulations permit them to claim funding for. Each firm's work mix will vary according to what other contracts they have with the Legal Aid Agency for other matter types.

Contracted lawyers providing representation before the MHT must be accredited by the Law Society as mental health specialists, and most are members of the Mental Health Lawyers Association ('**MHLA**'). These and other factors impacting on the quality of legal services provided by private firms are discussed in Chapter 5 below.

Non-legal mental health and disability advocacy services

Independent mental health advocates

In 2009, the MHA was amended to introduce the role of independent mental health advocates ('**IMHAs**'). There is a statutory duty to provide an IMHA to 'qualifying patients'¹³⁵ to help them obtain information and understanding about various matters, including:

- Their legal circumstances;
- Any conditions or restrictions;
- Any treatment given, proposed or discussed (and why it is given, proposed or discussed); and
- Any rights they may exercise under the MHA.¹³⁶

IMHAs are also required to help people, 'by way of representation or otherwise', in exercising their rights,¹³⁷ and have various statutory powers to enable them to perform their role. They provide instructions-based advocacy and work alongside, rather than replace, any other advocacy and support services (including legal services).

There are numerous different community organisations contracted to provide IMHA services across England.

In its 2013-14 annual report on the MHA, the CQC highlighted some deficiencies in the operation of the IMHA scheme. For instance, issues with access due to referral arrangements arose during 10% of CQC inspections, and there was limited evidence that patients were told of IMHA services in 22% of inspections.¹³⁸

¹³² Ministry of Justice (UK), *Legal Aid Agency Framework Document* (undated) 5. This document sets out the arrangements for the governance, accountability, financing, staffing and operation of the Legal Aid Agency.

¹³³ See directory of legal aid providers, available at <<https://www.gov.uk/government/publications/directory-of-legal-aid-providers>>.

¹³⁴ Ministry of Justice (UK), *Legal Aid Statistics in England and Wales: January to March 2015* (2015) 29.

¹³⁵ These include people who have been admitted to hospital for assessment or treatment (even if they are on leave) or are subject to guardianship or to a supervised CTO.

¹³⁶ *Mental Health Act 1983* (UK) s 130B(1), (2)(a).

¹³⁷ *Ibid* s 130B(2)(b).

¹³⁸ CQC, *Monitoring the Mental Health Act in 2013/14*, above n 82, 41.

Independent mental capacity advocates

Having regard to 'the principle that a person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision',¹³⁹ the MCA introduced a statutory duty to make sure that independent mental capacity advocates ('IMCAs') are available to represent and support people with disabilities in certain circumstances.¹⁴⁰

People over 16 years who are considered to lack mental capacity, and have no appropriate family or friends to support or represent them, must have access to an IMCA when a decision is being made about:

- Providing, withdrawing or stopping serious medical treatment;
- A change in the person's accommodation where the NHS or local authority are proposing a stay of more than eight weeks in a care home;
- A hospital stay of more than 28 days;
- Adult protection proceedings; and
- Care reviews.¹⁴¹

However, IMCAs do not provide services to people detained or treated under the MHA if the proposed treatment and accommodation/detention decisions are governed by that Act.

As with IMHAs, numerous different organisations are contracted to provide IMCA services across England. According to seAp, an IMCA service provider, IMCAs can:

- Work with and support the person who lacks capacity to find out their views, wishes and feelings, as far as is possible, and involve them in the decision-making process as much as possible;
- Represent the person's likely views to those responsible for making decisions about their care and treatment. If they cannot get instructions from the person, they will provide 'non-instructed advocacy',¹⁴² which is distinct from 'best interests' advocacy;¹⁴³
- Check that those working with the person adhere to the main principles of the MCA and act as a safeguard for the person's rights;
- Obtain and evaluate information on behalf of the person;
- Provide the Decision-Maker with a written report (the Pre-Decision report) which outlines what the likely views of the person are and makes recommendations for alternative courses of action and includes details of how they arrived at their recommendations. Decision-makers have a responsibility to give full consideration to the contents of the IMCA's Pre-Decision report;
- Visit the person again after the decision has been made and provide the Decision-Maker with a further written report (the Post-Decision report); and
- Challenge decisions and actions that have been taken. An IMCA can appeal on behalf of the person if they believe a decision has been made without due consideration being given to their report.¹⁴⁴

The CQC has highlighted some deficiencies in the IMCA scheme, noting that there are many instances where IMCAs should be appointed by a local authority but are not.¹⁴⁵

¹³⁹ Mental Capacity Act 2005 (UK) s 35(4).

¹⁴⁰ Ibid s 35(1).

¹⁴¹ Ibid ss 37-39D.

¹⁴² 'Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to give a clear indication of their views or wishes in a specific situation. The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for their unique preferences and perspectives': Office of the Public Guardian (UK), *Making decisions: The Independent Mental Capacity Advocate (IMCA) service* (2007) 9.

¹⁴³ 'IMCA advocacy is not best interests advocacy. The advocate does not offer their own opinion': ibid 10.

¹⁴⁴ seAp, 'What is independent mental health advocacy?' <<http://www.seap.org.uk/services/independent-mental-capacity-advocacy/what-is-independent-mental-capacity-advocacy.html>>. See also *Mental Capacity Act 2005* (UK) s 36 (functions of IMCAs).

¹⁴⁵ CQC, *Monitoring the use of the Mental Capacity Act deprivation of liberty safeguards in 2013/2014* (2015) 28.

CHAPTER 3:

MENTAL HEALTH LEGAL SERVICES IN ACTION

This chapter looks at how mental health legal services act and seek to influence others to protect the rights of individual clients with disabilities who are detained for compulsory treatment in closed environments. It covers the following four matters:

- A. How compulsory inpatients obtain legal assistance;
- B. Protecting rights in judicial contexts: mental health courts and tribunals;
- C. Protecting rights in administrative contexts: hospitals and clinicians; and
- D. How informally detained people with disabilities obtain legal assistance.

The rights focused on in this chapter are statutory rights and human rights to the extent they are protected by the domestic legal system. Parts 3A, 3B and 3C focus on compulsory inpatients who have been formally detained and Part 3D focuses on people who have been informally detained.

3A. HOW COMPULSORY INPATIENTS OBTAIN LEGAL ASSISTANCE

How is access to legal assistance relevant to rights protection for compulsory inpatients?

It is hard for a person to assert their rights if they are not aware of their rights or how to exercise them. Accordingly, lawyers can directly help to protect the rights of compulsory inpatients by:

- Providing them with legal advice and information about their rights and how the law applies in their specific situation;
- Acting on their instructions and assisting them to seek the removal or reduction of restrictions on their rights; and
- Providing legal representation at mental health hearings, and triggering such hearings if necessary.

However, a lawyer cannot do any of these things unless they know about and are able to act for the person. Accordingly, whether and how a compulsory inpatient obtains legal advice and representation for mental health hearings will significantly impact on the extent to which their rights are protected.

In conducting this research, the following factors emerged as having a significant bearing on the question of how compulsory inpatients obtain legal assistance:

- How compulsory inpatients connect with lawyers and get legal advice;
- Who is entitled to legal representation for mental health hearings;
- What legal representation, if any, does a compulsory inpatient receive if they lack the capacity to instruct a lawyer; and
- Whether the legal service system is able to meet demand for representation.

How compulsory inpatients connect with lawyers and get legal advice

Any entitlement to legal representation is of limited use if you do not know how and/or are not supported to access a lawyer. Accessing a lawyer while detained is not always a straightforward matter. However, effective – albeit very different – systems are in place in both New York and England which mean that compulsory inpatients have little difficulty connecting with lawyers and getting legal advice.

‘We try to make sure that everyone is seen... I don’t want the people who are quiet or don’t know about us to fall through the cracks.’

– Sara Rollyson, MHLS, New York

Mandate and regular presence: New York

The MHLS’ statutory position and mandate is extremely significant in ensuring that patients are swiftly connected with them. The New York *Mental Hygiene Law* requires hospitals to inform patients of the availability of MHLS lawyers both upon their admission and again following any change in their legal status.¹⁴⁶ The law also requires that the MHLS is given notice whenever someone is involuntarily admitted to hospital.¹⁴⁷ In turn, the MHLS is under a duty to ‘study and review the admission and retention of all patients or residents’ and meet with them all to inform them of their rights and provide legal services as necessary.¹⁴⁸ MHLS principal attorney Sara Rollyson said:

We try to make sure that everyone is seen. I feel like it is very important to at least let clients know that we are available to them and see if they have any questions and make sure that our clients understand all of their rights...

We have attorneys that cover the ER [Emergency Room and] the CPEP [Comprehensive Psychiatric Emergency Program] when patients first come in, and when they are in extended observation beds... We try to see them there and then we try to see them in the units as well. Every time they have a change of legal status, we try to see them again... I don’t want the people who are quiet or don’t know about us to fall through the cracks.

To facilitate their role, many hospitals send their local MHLS office an updated patient census every day, allowing MHLS lawyers to identify any new patients and changes in legal status.¹⁴⁹ Not all hospitals provide such a list: ‘you might just have to be a little more aggressive in getting it’.¹⁵⁰ Kings County Hospital’s cooperation in this regard reflects a ‘hard fought victory’¹⁵¹ rather than a good relationship with the hospital, likely influenced by the settlement reached in a lawsuit brought against them by the MHLS for patient abuse and appalling conditions (see box ‘Fight to improve conditions at Kings County Hospital: *Hirschfeld vs New York City Health and Hospitals Corporation*’ in Part 4C below).

Irrespective of where their base office is located, because of their clear statutory mandate, MHLS staff are thoroughly accepted within the hospitals in which they work and can move freely about to access clients. The statute requires the MHLS to be granted unfettered access,¹⁵² and MHLS staff are even given keys or swipe cards to the wards (at least at some hospitals).¹⁵³ As a result, Sara said:

[S]ometimes you will get some clients who think you work for the hospital. Usually I can sit down and convince them otherwise. I mean I have been at Kings County for so long now if I haven’t met that client before there is someone else in the unit who is like, ‘She is fine’.¹⁵⁴

Being the sole legal service provider in this area, the MHLS is well known among people who are regularly brought into hospital or who are likely to be. Each MHLS lawyer is allocated to particular wards or hospitals, and their regular and consistent presence allows them to form and maintain ongoing relationships with their clients. Patients have a good knowledge of MHLS services and will reach out to them.

At a practical level, the MHLS’ frequent presence within each hospital makes it easy for people to connect with them and vice versa: ‘We are also just a presence in the unit so even just being there... people are more likely to grab you and be like, ‘I have this issue’’.¹⁵⁵ Both walking into the hospital building and around the floors, a number of patients identified and approached to the MHLS lawyer I was with to chat or provide updates about their situation.

¹⁴⁶ Mental Hygiene Law § 9.07.

¹⁴⁷ ‘Except as to informal patients and patients admitted pursuant to section 9.39 or 9.40, the director of a hospital shall within five days, excluding Sunday and holidays, after the admission of any patient forward to the [MHLS] a record of such patient and shall simultaneously forward to the department such information from the record as the commissioner by regulation shall require’: *ibid* § 9.11; also, ‘[t]he director shall cause written notice of a person’s involuntary admission on an application supported by medical certification to be given forthwith to the [MHLS]’: § 9.29(a). A similar provision applies in relation to emergency admissions for immediate observation, care and treatment under § 9.39(a).

¹⁴⁸ *Ibid* § 47.03(a), (b), (c).

¹⁴⁹ This was reported at both the Kings County Hospital in Brooklyn and BPC in the Bronx. *Mental Hygiene Law* § 47.03(d) requires the MHLS ‘[t]o be granted access at any and all times to... all books, records and data pertaining to any such facility or place deemed necessary for carrying out its functions, powers and duties’.

¹⁵⁰ Sara Rollyson.

¹⁵¹ *Ibid*.

¹⁵² *Mental Hygiene Law* § 47.03(d) provides that the MHLS must ‘be granted access at any and all times to any facility or place or part thereof’.

¹⁵³ Sara Rollyson.

¹⁵⁴ *Ibid*.

¹⁵⁵ *Ibid*.

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Sir Stanley Burnton, speaking at a seminar, 'Public law in an age of austerity', London, 4 June 2015. Sir Burnton chaired the JUSTICE working party which produced the report, *Delivering Justice in an Age of Austerity* (2015).

157

Tam Gill.

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CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 45.

159

CQC and Administrative Justice and Tribunals Council, *Patients' experiences of the First-Tier Tribunal (Mental Health): Report of a joint pilot project of the Administrative Justice and Tribunals Council and the CQC* (2011) 4.

160

A further reason for not providing telephone advice is that, without seeing the client and having them sign a retainer, the firm's insurance would not cover any potentially negligent advice (for instance, if they are not given all the facts and consequently provide incorrect advice based on inaccurate information); Peter Edwards' staff.

161

Tribunal Procedure (First-tier Tribunal) Rules 2008 (UK) r 11(7).

162

YA v Central and NW London NHS Trusts and Others [2015] UKUT 37, [58]: In order to make an informed refusal of legal representation, 'the factors that the patient will have to be able to sufficiently understand, retain, use and weigh will be likely to include the following:

- i. 'the detention, and so the reasons for it, can be challenged in proceedings before the tribunal who, on that challenge, will consider whether the detention is justified by the provisions of the MHA,
- ii. 'in doing that, the tribunal will investigate and invite and consider questions and argument on the issues, the medical and other evidence and the legal issues,
- iii. 'the tribunal can discharge the section and so bring the detention to an end,
- iv. 'representation would be free,
- v. 'discussion can take place with the patient and the representative before and so without the pressure of a hearing,
- vi. 'having regard to that discussion a representative would be able to question witnesses and argue the case on the facts and the law, and thereby assist in ensuring that the tribunal took all relevant factual and legal issues into account,
- vii. 'he or she may not be able to do this so well because of their personal involvement and the nature and complication of some of the issues (e.g. when they are finely balanced or depend on the likelihood of the patient's compliance with assessment or treatment or relate to what is the least restrictive available way of best achieving the proposed assessment or treatment),
- viii. 'having regard to the issues of fact and law his or her ability to conduct the proceedings without help, and so the impact of these factors on the choice to be made'.

Strong informal supports and referral practices: England

In complete contrast to New York, there is no mandated legal service or centralised contact point to obtain legal assistance in England. There is not even an effective phone service: a recent review found that the 'roundly-criticised' legal aid civil law telephone gateway is 'not fit for purpose in its current form' (the report in fact notes the quality of online and telephone legal information services in Australia and recommended that England emulate these).¹⁵⁶

While MHLS lawyers are empowered and required by their mandate to proactively approach inpatients to offer them assistance, private lawyers in England have no mandate to represent anybody and are not permitted to 'fish' for clients. They primarily rely on patients being periodically reminded of their rights to legal representation, or IMHAs, to contact them with requests and referrals for legal representation.¹⁵⁷

Section 132 of the MHA requires the detaining service to periodically provide compulsory inpatients with information about their rights, including the right to legal assistance, in a form that they can understand. CQC audits in 2014-2015 confirmed that there were written records of attempts to discuss rights with patients upon their admission in 91% of cases and periodically in 84% of cases, with these figures gradually increasing.¹⁵⁸ The fact that this is a periodic rather than one-off obligation increases the chance of a person understanding and acting on their rights and decreases the likelihood they will simply acquiesce to a service they do not actually want.

The MHA administrator at Broadmoor Hospital, Sheena Ebsworth, said it was critical that patients understand their rights, and that the hospital encourages access to lawyers from day one. A list of available lawyers is provided and hospital staff facilitate contact due to phone restrictions (Broadmoor is a high secure facility). Aside from the formal requirements under s 132, the West London Mental Health NHS Trust (which operates Broadmoor) has a policy of discussing rights with patients at least every six months plus on certain other triggers (the policy on informing patients of their rights under s 132 runs to 21 pages). This does not just involve handing the patient a document but requires an actual discussion, the substance of which is documented in the file. One of the things that Sheena and the other MHA administrators audit is the quality of file notes of these discussions, which are an indication of the quality of the discussions themselves (the role of MHA administrators is discussed in Part 3C below).

Lawyer John O'Donnell, who has worked in the field for decades, felt there are enough safeguards in place to ensure that people are not languishing in detention without legal assistance. Both he and Peter Edwards also believed that hospitals want their patients to have quality representation and would direct patients towards the good firms on the list of available lawyers.

Speaking as a service user, Ian Callaghan said it is 'very easy to get hold of a lawyer'. This was confirmed by the CQC and Administrative Justice and Tribunals Council's research into patient experiences of the MHT, which found that '[n]early all respondents knew they were entitled to have a lawyer to advise them and represent them at the tribunal hearing and generally had no problem finding one'.¹⁵⁹

Following a referral or request for assistance, private lawyers primarily provide legal advice to compulsory inpatients in person, at least for new clients. In part, this is because it is good practice but it is also because firms are limited by Legal Aid Agency guidelines in what funding they can claim if they provide advice over the phone. Lawyers at Peter Edwards' firm said that if a person called up seeking advice for a matter for which they could provide a service, administrative staff would arrange for a lawyer to visit them. However, the lawyers rarely provide legal advice over the phone because if they do, the firm bears the risk that the matter will not lead to any funding.¹⁶⁰ It is possible that the practical requirement for a caller to provide enough relevant information over the phone to establish that their matter would attract funding may make it more difficult for people with communication difficulties and/or who struggle to explain their legal situation to access a lawyer.

In addition to self-referrals and the role of the health service in facilitating legal representation, the MHT also plays an important role in facilitating legal representation. If a person with a scheduled MHT hearing states they want to be legally represented and/or does not want to conduct their own case, the MHT can appoint a lawyer to represent them¹⁶¹ and will do so in practice. If a person makes an informed refusal of legal representation,¹⁶² they are entitled to represent themselves. However, this is rare.

‘Nearly all respondents knew they were entitled to have a lawyer to advise them and represent them at the tribunal hearing and generally had no problem finding one.’

– CQC and Administrative Justice and Tribunals Council, 2011

Limitations of this approach

While these processes allow legal representation in relation to hearings that have already been scheduled, they do not necessarily provide a satisfactory solution for supporting people who do not already have a hearing scheduled to obtain legal assistance. Notwithstanding the statutory requirement to provide information about rights to all people detained under the MHA, some of those people may nevertheless be unable to appreciate or independently act on their right to request a hearing due to significant cognitive deficits, acute symptoms of mental illness, medication side effects or other factors.

At the time I met with her, academic Dr Lucy Series expressed concern that there are not strong enough safeguards and duties to help people in this situation link in with lawyers and advocacy services. While people detained under the MHA must be informed about IMHA services and how IMHAs can help them,¹⁶³ the IMHA model essentially relies on self-referrals and there has traditionally been no onus on services to actually refer a person who may need independent advice or support to an IMHA. Even if an IMHA is contacted, because IMHA involves instructions-based advocacy, Lucy said that there have been ‘problems with IMHAs not wanting to work with clients who lack capacity, as they don’t regard them as able to give instructions’.¹⁶⁴ However, in somewhat circular fashion, people lacking mental capacity who are detained under the MHA are not entitled to IMCA services because ‘the safeguards available under the [MHA] will apply’.¹⁶⁵ Accordingly, for someone who is unable to self-refer to an IMHA or lawyer, or to ask an IMHA or lawyer to request a hearing on their behalf, ‘this is a bit of a rubbish system’.¹⁶⁶

In 2014, the ECtHR found that the lack of special safeguards and supports to enable a compulsory inpatient with Downs Syndrome to exercise her right to seek independent judicial review of her detention (by bringing on her case for hearing before the MHT) breached article 5(4) of the ECHR.¹⁶⁷ The fact that review hearings are scheduled periodically even if a compulsory inpatient takes no action was not considered adequate to protect this right.

While there have been no statutory changes in response to this decision,¹⁶⁸ revisions to the *Mental Health Act 1983: Code of Practice* (**‘Code of Practice’**)¹⁶⁹ in April 2015 go some way towards facilitating IMHA access and mental health hearings for people with limited ability to self-request those things:

- Hospital managers should ensure that ‘patients are well-informed and supported to make an application to the [MHT] if they... do not otherwise have regular contact with their nearest relative or people who could help them make an application, or lack capacity. If a patient lacks capacity to decide whether to seek a review of detention or a CTO, an IMHA should be introduced to the patient so that the IMHA can explain what help they can offer’.¹⁷⁰
- Hospital managers ‘should normally’ ask the Secretary of State for Health to refer a compulsory inpatient’s case to the MHT where the person ‘lacks the capacity to request’ a mental health hearing themselves, and ‘should consider [doing so] in respect of any patients whose rights under article 5(4) of the ECHR might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the [MHT] speedily following their initial detention or at reasonable intervals afterwards’.¹⁷¹

Nevertheless, Lucy felt that people could still fall between the gaps. This issue is discussed further in Part 3D below.

¹⁶³ *Mental Health Act 1983* (UK) s 130D.

¹⁶⁴ Lucy referred to a 2012 study by University of Central Lancashire, *The Right to Be Heard: Review of Independent Mental Health Advocate (IMHA) Services in England*, available at <http://www.uclan.ac.uk/research/explore/projects/the_right_to_be_heard.php>.

¹⁶⁵ Office of the Public Guardian (UK), above n 142, 24.

¹⁶⁶ Lucy Series.

¹⁶⁷ *MH v UK* (2014) 58 EHRR 35, [81]–[82], [86]–[87].

In the case of *Winterwerp*, the Court held that it was essential for the patient to have access to a court and the opportunity to be heard either in person or, where necessary, through some form of representation; that mental illness could entail restricting or modifying the manner of exercising that right, but could not justify impairing its very essence; and that special procedural safeguards might be called for in order to protect the interests of persons who, on account of their mental disabilities, were not fully capable of acting for themselves. As the right set forth in Article 5 § 4 of the Convention is guaranteed to everyone, it is clear that special safeguards are called for in the case of detained mental patients who lack legal capacity to institute proceedings before judicial bodies... The special safeguards required under Article 5 § 4 for incompetent mental patients in a position such as hers were lacking in relation to the means available to her to challenge the lawfulness of her “assessment detention” in hospital for a period of up to twenty-eight days. Therefore, in the particular circumstances of the present case there was a violation of Article 5 § 4 of the Convention in relation to the applicant’s initial detention by administrative order for the purposes of medical assessment in hospital.

¹⁶⁸ Lucy Series.

¹⁶⁹ Department of Health (UK), *Code of Practice*, above n 95. See also ‘Code of Practice’ in Part 3C below.

¹⁷⁰ Department of Health (UK), *Code of Practice*, above n 95, [4.23]. The Code confirms that IMHAs can help a person apply for a mental health hearing: [6.13].

¹⁷¹ *Ibid* [37.44]–[37.46].

Reflections

It is not surprising that the MHLS' clear statutory mandate ensures compulsory inpatients in New York are well connected to lawyers; it is clearly more straightforward and efficient in terms of access to representation to have a single, easily recognisable legal service regularly on site, if not co-located, at each hospital. However, I was somewhat surprised to learn that England's more informal system also seemed to work quite well in practice, at least in relation to people with the capacity to request assistance.

In Victoria, as there is no legal service with a statutory mandate to proactively approach or represent people, the provision of legal assistance is largely reactive. MHDL has established a practice whereby our lawyers attend most hospitals the day before scheduled hearings and offer services to any compulsory inpatient who already has a hearing listed the following day. Beyond this, like English lawyers, we rely on patients or staff to directly contact us and request assistance. However, the level of support provided by Victorian mental health services to link compulsory inpatients with lawyers varies significantly.

Compared to Victoria, the following factors seem to provide better support for English compulsory inpatients to access lawyers:

- Patients know they are entitled to legal representation and will receive it if they request it (and they will not have been negatively reinforced by previous rejections from legal services unable to meet demand for assistance).
- Because mental health services recognise that hearings will not proceed without legal representation, they will provide support to access a lawyer in a timely fashion (near-universal levels of legal representation reinforce the idea that a lawyer must be arranged).
- There are greater notice periods before hearings during which legal representation can be organised. In England, other than hearing applications made within the first 14 days of admission (for which at least three business days' notice must be given), at least three weeks' notice of the hearing must be given.¹⁷²
- Clinicians, hospital staff and the MHT have a more consistently positive attitude towards lawyers and highly value legal representation (see Parts 3B and 3C below).

In Victoria, while the *Mental Health Act 2014* (Vic) provides that people 'may be represented before the Tribunal by any person authorised to that effect by the person who is the subject of the proceeding',¹⁷³ the MHT does not take any responsibility for facilitating this: its annual report states that 'legal representation at the Tribunal is not an automatic right and it is the responsibility of patients to arrange their own representation'.¹⁷⁴ The MHT does have the power to 'appoint another person to represent' an unrepresented person appearing before it.¹⁷⁵ However, while the MHT sometimes adjourns hearings to enable a person to seek legal representation and, on occasion, has referred a person to VLA to provide legal representation, we are not aware of the MHT having appointed a representative under this provision. We are also not aware of whether these adjournments and referrals are only made at the request of the unrepresented person or on the initiative of the MHT as well. In 2014-2015, only 57% of people attended their MHT hearings in Victoria¹⁷⁶ and only around 18% of hearings involved legal representation.¹⁷⁷ It is reasonable to assume that at least some more people would chose to attend their hearings if they were able/assisted to access legal representation.

Who is entitled to legal representation?

In New York and England (as well as Washington DC, New Jersey and Hungary), essentially all compulsory inpatients are entitled to legal representation at hearings related to their detention and compulsory treatment.

In New York, the *Mental Hygiene Law* establishes a statutory entitlement to state-funded legal representation (for both those detained and those subject to compulsory treatment in the community) through the mandated duties and functions of the MHLS to provide such representation. This right stems from due process rights in the US constitution,¹⁷⁸ and the service is not means-tested.

¹⁷² *Tribunal Procedure (First-tier Tribunal) Rules 2008* (UK) r 37.

¹⁷³ *Mental Health Act 2014* (Vic) s 184(3).

¹⁷⁴ MHT (Victoria), *2014/2015 annual report*, above n 15, 26.

¹⁷⁵ *Mental Health Act 2014* (Vic) s 184(4).

¹⁷⁶ MHT (Victoria), *2014/2015 annual report*, above n 15, 26. The report does not break down the percentage of patients who attended according to whether they are inpatients or being treated in the community. The attendance rate is a small increase on the steady 50% who attended Mental Health Review Board hearings in the years prior to the July 2014 commencement of the MHT.

¹⁷⁷ *Ibid* 26.

¹⁷⁸ In the forthcoming third edition of his treatise on mental disability law, Emeritus Professor Michael Perlin and co-author Heather Ellis Cucolo explain, 'Although the U.S. Supreme Court has never found specifically that there is a constitutional right to counsel at involuntary civil commitment proceedings, virtually every federal appeals court and high state court that has dealt with the question has found such a right. In response to these decisions and to the historic reality that persons with mental disabilities have traditionally received grossly inadequate legal services, many states have mandated—through statute and/or court rule—the provision of counsel to those facing commitment': *Mental Disability Law: Civil and Criminal* (LexisNexis, 3rd ed, 2015) § 6-1, at 6-2.

In England, legal representation for MHT matters is funded by the Legal Aid Agency. The Legal Aid Authority states '[t]here is a statutory duty to provide advice and representation in [mental health] cases, and they are funded without reference to a client's means'.¹⁷⁹ The only merits criterion to be eligible for legal representation before the MHT (again, regardless of whether the person detained or in the community) is that 'it would be reasonable in all the circumstances of the case for the individual to be provided with full representation'.¹⁸⁰ While what is 'reasonable' is somewhat opaque, the Legal Aid Agency's Standard Civil Contract for mental health work states that it 'would be unusual' for it to be considered unreasonable to fund a MHT matter.¹⁸¹ The MHLA further states that MHT matters are 'invariably' considered reasonable,¹⁸² especially if the matter involves someone seeking to be released from detention.

The Legal Aid Agency's provision of what is essentially universal funding for legal representation in all mental health hearings derives from human rights principles and case law from the ECtHR, such as *Winterwerp v Netherlands*¹⁸³ and *Megyeri v Germany*.¹⁸⁴ The UK Law Society's practice note on representation before the MHT explains the basis for this right to legal representation:

The right of access to a court is a fundamental right at common law... and is guaranteed by Article 6 of the [ECHR].

Article 5(4) of the [ECHR] further guarantees the right to legal representation. When an individual is detained on the grounds of mental disorder, Article 5(4) requires that effective legal representation is provided by the state, free of charge, unless there are 'special circumstances'...

'Special circumstances' do not include the fact that the detainee's prospects of release are poor or that the detainee has the means to instruct his [or her] own lawyers. Even if representation is available (whether at the detainee's or the state's expense) the state must still ensure the detainee is represented unless satisfied that he or she has capacity and has made an informed choice not to be represented.¹⁸⁵

Does human rights law require the provision of legal representation in order for a mental health hearing to be fair and, consequently, for detention to be lawful?

Article 5(4) of the ECHR provides that '[e]veryone who is deprived of [their] liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of [their] detention shall be decided speedily by a court and [their] release ordered if the detention is not lawful'. It is very similar to the right protected by s 21(7) of the Victorian Charter.¹⁸⁶

The ECtHR has recognised the following 'fundamental guarantees of procedure'¹⁸⁷ without which the deprivation of liberty of persons on the basis of alleged disability will breach article 5(4):

- (a) '[A]n initial period of detention may be authorised by an administrative authority as an emergency measure provided that it is of short duration and the individual is able to bring judicial proceedings "speedily" to challenge the lawfulness of any such detention including, where appropriate, its lawful justification as an emergency measure;
- (b) '[F]ollowing the expiry of any such initial period of emergency detention, a person thereafter detained for an indefinite or lengthy period is in principle entitled, at any rate where there is no automatic periodic review of a judicial character, to take proceedings "at reasonable intervals" before a court to put in issue the "lawfulness" – within the meaning of the [ECHR] – of his detention;
- (c) 'Article 5 § 4 requires the procedure followed to have a judicial character and to afford the individual concerned guarantees appropriate to the kind of deprivation of liberty in question; in order to determine whether proceedings provide adequate guarantees, regard must be had to the particular nature of the circumstances in which they take place.'¹⁸⁸

In order for these judicial-type hearings to be an adequate safeguard, they must be fair.¹⁸⁹

¹⁷⁹ Ministry of Justice (UK), *Legal Aid Statistics*, above n 134, 29. The exemption from the means test is set out at *Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013* (UK) reg 5(1)(f).

¹⁸⁰ *Civil Legal Aid (Merits Criteria) Regulations 2013* (UK) reg 51.

¹⁸¹ Legal Aid Agency, 2014 *Standard Civil Contract Mental Health Specification: Category Specific Rules* (2014) [7.35].

¹⁸² MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 125.

¹⁸³ (1979) 2 EHRR 387.

¹⁸⁴ (1992) 15 EHRR 584.

¹⁸⁵ Law Society, *Practice Note: Representation before mental health tribunals*, 22 January 2015 [2].

¹⁸⁶ Section 21(7) of the Charter provides that '[a]ny person deprived of liberty by arrest or detention is entitled to apply to a court for a declaration or order regarding the lawfulness of his or her detention, and the court must (a) make a decision without delay; and (b) order the release of the person if it finds that the detention is unlawful'.

¹⁸⁷ *Winterwerp v Netherlands* (1979) 2 EHRR 387, [60].

¹⁸⁸ *MH v UK* (2014) 58 EHRR 35, [77].

¹⁸⁹ Article 6(1) of the ECHR states, 'In the determination of his civil rights and obligations... everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law'. Similarly, s 24(1) of the Charter states, 'a party to a civil proceeding has the right to have the... proceeding decided by a competent, independent and impartial court or tribunal after a fair and public hearing'.

Back in 1991, the United Nations General Assembly declared in its *Principles for the Protection of Persons with Mental Illness* that a 'person whose capacity is at issue shall be entitled to be represented by a counsel' and, further, that if the person does not arrange their own legal representation, 'counsel shall be made available without payment to that person to the extent that he or she does not have sufficient means to pay for it'.¹⁹⁰ However, the ECtHR has not gone quite so far as to determine that fair hearing requirements demand legal representation in every mental health hearing. In 2013, in *MH v UK*, the ECtHR held that:

[T]he judicial proceedings referred to in Article 5 § 4 need not always be attended by the same guarantees as those required under Article 6 § 1 for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard either in person or, *where necessary*, through some form of representation[.]

[S]pecial procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental disabilities, are not fully capable of acting for themselves (emphasis added, citations removed).¹⁹¹

In *Megyeri v Germany*,¹⁹² the ECtHR found 'that where a person is confined in a psychiatric institution on the ground of the commission of acts which constituted criminal offences but for which he could not be held responsible on account of mental illness, *he should - unless there are special circumstances - receive legal assistance in subsequent proceedings relating to the continuation, suspension or termination of his detention. The importance of what is at stake for him - personal liberty - taken together with the very nature of his affliction - diminished mental capacity - compel this conclusion...* It is doubtful, to say the least, whether Mr Megyeri, acting on his own, was able to marshal and present adequately points in his favour on this issue, involving as it did matters of medical knowledge and expertise. Again, it is even more doubtful whether, on his own, he was in a position to address adequately the legal issue arising [namely, the proportionality of his continued detention]' (emphasis added).¹⁹³

In 2015, the English Upper Tribunal considered how Megyeri applied to non-forensic mental health hearings before the MHT.¹⁹⁴

Paragraph 23 of *Megyeri* does not give examples of what would be special circumstances or indicate the importance to the issue of representation of the detained person having committed, or the likelihood that he would if released from detention commit, acts that would be criminal (if he could be held responsible for them). However, the "special circumstances" qualification is an indication that:

- i. [I]t is necessary to look at all the relevant circumstances to determine whether in a given case compliance with Article 5(4), and also its objectives, requires that a person who lacks capacity has legal representation before the reviewing body, and
- ii. [W]here, as in *Megyeri*, the combination of circumstances founds the view that it is doubtful to say the least that the detained person, acting on his own, would be able to marshal and present the points in his favour on the facts, medical evidence and opinion and proportionality, it will only be in special circumstances that it can be said that the person does not need legal representation.

To my mind... the approach of the court in *Megyeri* recognises and preserves the necessary flexibility in the application of Article 5(4) and reflects, for example, the approach taken in an Article 6 case, *P, C and R v the UK* (2002) 35 EHRR 31 where, at paragraph 89, the court commented that failure to provide the assistance of a lawyer may breach Article 6 where such assistance is indispensable for effective access to court by reason of the complexity of the procedure or the type of case. And so, for example, in all the relevant circumstances it was unrealistic to suppose that the party could effectively conduct her own case despite the assistance afforded by the judge to a litigant in person.

¹⁹⁰ United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted by the General Assembly 17 December 1991), principle 1(6), also 18(1).

¹⁹¹ *MH v UK* (2014) 58 EHRR 35, [77].

¹⁹² (1992) 15 EHRR 584.

¹⁹³ Ibid [23], [25].

¹⁹⁴ *YA v Central and NW London NHS Trusts and Others* [2015] UKUT 37, [39]-[41].

In light of this, the Upper Tribunal considered the following to be the ‘most important principles’ when considering whether the MHT would need to exercise its power to appoint a legal representative for an unrepresented person in order for the mental health hearing to conform with the fair hearing requirements:

- ‘[T]he underlying purpose and importance of the review and so the need to fairly and thoroughly assess the reasons for the detention,
- ‘[T]he vulnerability of the person who is its subject and what is at stake for that person (i.e. a continuation of a detention for an identified purpose),
- ‘[T]he need for flexibility and appropriate speed,
- ‘[W]hether, without representation (but with all other available assistance and the prospect of further reviews), the patient will practically and effectively be able to conduct their case, and if not whether nonetheless
- ‘[T]he tribunal is likely to be properly and sufficiently informed of the competing factors relating to the case before it and so be able to carry out an effective review. (As to this the tribunal should when deciding the case review this prediction).’¹⁹⁵

Therefore, the MHT must determine in each individual case whether the absence of legal representation would render the hearing unfair and therefore an inadequate safeguard. Without close scrutiny of the person and their circumstances, the MHT will be unable to determine the person’s ability to marshal and present the points in their favour on the facts, medical evidence and the law, and whether there might be additional relevant information which will not be brought to its attention if the person does not have the benefit of legal representation. If the MHT proceeds to conduct a hearing where the person is unrepresented or absent (even where no request for legal assistance has been made) without first satisfying itself that representation is not required, there is a real risk that the hearing will be unfair and thus an insufficient safeguard against arbitrary detention.

Reflections

Unlike New York and England, Victoria does not provide a universal entitlement to legal representation for people at MHT hearings, let alone for compulsory inpatients who are being detained.

Over 90% of all MHT legal representation in Victoria is provided by VLA/MHDL’s duty lawyer service. Under this model, salaried lawyers provide free outreach legal services, including MHT representation, to compulsory inpatients in most hospitals. This service is not means-tested and does not have strict eligibility criteria or a formal application process. Instead, services are provided at the discretion of the duty lawyer in accordance with internal guidelines: as well as people whose case has objective legal merit, MHDL prioritises representing people who are young, who have a dual disability, who would otherwise have difficulty communicating and representing themselves and/or for whom it is their first psychiatric admission or first MHT hearing (as such people are less likely to be able to obtain a fair hearing without legal representation). However, there are a number of limitations to the duty lawyer service:

- The duty lawyer is usually limited to representing up to three people per hearing day, so not everyone who would like to receive representation is able to do so.
- Because it operates only on the regular MHT hearing days at each hospital, it is typically unavailable for inpatients whose hearings have been scheduled on an ‘ad hoc’ basis.
- There are a couple of regional hospitals where the duty lawyer service does not operate consistently.
- As people being detained are prioritised, it provides quite limited assistance to people on CTOs.

¹⁹⁵
Ibid [45].

In stark contrast to the near-universal rates of representation in New York and England, 82% of Victorians did not have legal representation at their MHT hearings in 2014-2015.

If the duty lawyer service is unable to represent them at their MHT hearing, a person (whether an inpatient or on a CTO) may apply to VLA for a grant of state-funded legal assistance. Eligibility for these grants is governed by formal guidelines set by VLA's Board, which are more restrictive than the guidelines for the duty lawyer service. A person may only receive a grant for representation at an MHT hearing if they have 'a reasonable prospect of either obtaining their release from hospital [or] some other improvement in their condition'.¹⁹⁶ The matter must also meet a means test¹⁹⁷ and the 'state reasonableness test' (which requires consideration of whether the matter is likely to terminate in a manner favourable to the person).¹⁹⁸ In 2014-2015, only 40 grants of legal assistance were made under the MHT guideline (39 of which were made to VLA lawyers to provide representation outside the context of the duty lawyer service, and one was made to a private lawyer).¹⁹⁹

In stark contrast to the near-universal rates of representation in New York and England, 82% of Victorians did not have legal representation at their MHT hearings in 2014-2015.²⁰⁰ One factor which perhaps makes the absence of a universal entitlement to legal representation for mental health hearings more acceptable is that, under Victoria's mental health law, a patient can apply to the MHT at any time for a hearing to determine whether they still meet the criteria for compulsory treatment. As patients can apply as often as they want, they could theoretically have a hearing every few weeks if they wanted to. Providing legal representation for hearings at such frequencies would not be a prudent use of public funds. As the ECtHR has noted, 'different considerations may apply, as regards the need to appoint counsel, where a detainee applies for release more frequently than "at reasonable intervals"'.²⁰¹ However, it is our experience that, in practice, few Victorian patients seek to exercise their rights to review so repetitively, learning quickly that it is futile to do so. Therefore, this difference in our legal system does not sufficiently explain or justify the significant difference in rates of legal representation.

Unless they meet the restrictive guideline for a grant of legal assistance or they are able to obtain the discretionary assistance of a VLA duty lawyer, a person in Victoria is not currently entitled to state-funded legal representation for their MHT hearing even in circumstances where the absence of representation would render that hearing unfair. This is concerning because, if a person is unable to organise legal representation, the existing practice of the MHT is simply to proceed with the potentially unfair hearing.²⁰²

While VLA is concerned about this situation, it is not currently financially feasible for VLA to significantly expand entitlement to legal representation through its existing duty lawyer service or the MHT funding guideline. VLA receives finite funding, and all of its guidelines and services are carefully calibrated against the total funding available. Therefore, in the absence of a substantial new funding injection from the State, VLA could only increase eligibility for MHT representation by decreasing the provision of legal assistance in other important matters.

¹⁹⁶ VLA, 'State civil law guideline 2 – Mental Health Tribunal cases' in *VLA Handbook for lawyers* <<http://handbook.vla.vic.gov.au>>.

¹⁹⁷ VLA, 'Means test' in *VLA Handbook for lawyers*, above n 196.

¹⁹⁸ 'Under the State reasonableness test, the person's lawyer (if any) or [VLA] must consider:

- 'the nature and extent of any benefit which a grant of legal assistance might give to: the person, the public, or any section of the public;
- 'the nature and extent of any detriment which a refusal of a grant of legal assistance might cause to: the person, the public, or any section of the public [and]
- 'in the case of assistance in relation to a proceeding in a court other than a criminal appeal – whether the proceeding is likely to terminate in a manner favourable to the person'.

VLA, 'State reasonableness test' in *VLA Handbook for lawyers*, above n 196.

¹⁹⁹ Notwithstanding the limited scope of VLA's guideline for MHT representation, it is currently significantly under-utilised and many people who are eligible for funding (particularly people on CTOs) simply do not request that assistance. This is likely due to a combination of people not being aware of their entitlements or encouraged to access legal representation, as well as the limited number of private law firms that actually have the experience to assist them.

²⁰⁰ MHT (Victoria), *2014/2015 annual report*, above n 15, 26.

²⁰¹ *Megyeri v Germany* (1992) 15 EHRR 584, [26].

²⁰² The MHT will sometimes adjourn a hearing if an unrepresented person indicates they would like legal representation, but if the person is not eligible for legal assistance from VLA or otherwise able to arrange legal representation, the MHT will proceed to conduct the hearing on the return date in the absence of legal representation.

Legal representation for compulsory inpatients lacking capacity to instruct a lawyer

Lawyers are under a professional and ethical duty to only act on their client's instructions. This begs the question, if a lawyer meets a potential client but believes they lack the mental capacity to instruct them, how does that person get legal representation?

This does not seem to be an issue in New York. The MHLS' mandated function in mental health hearings is to challenge the State to meet its burden and prove its case fairly in every hearing. Even if the patient has not instructed the MHLS or they want to represent themselves, an MHLS lawyer will appear in court anyway and inform the court of the situation. The Court will then decide whether to allow the person to represent themselves or whether the MHLS should represent them. I did observe one hearing where a patient was granted permission by the judge to represent himself, but the formality of the process makes this exceedingly difficult (he ended up asking the MHLS lawyer sitting next to him at the bar table to take over after too many objections by the Attorney-General's representative were sustained against his cross-examination of the psychiatrist).

When representing individuals with diminished capacity, MHLS lawyers are ethically required to maintain a conventional attorney-client relationship as far as reasonably possible.²⁰³

The people most likely to durably lack the mental capacity to instruct a lawyer are those with significant cognitive impairments. It may therefore be expected that there are proportionally more compulsory inpatients in England lacking the capacity to instruct a lawyer than in other jurisdictions because, as noted above, people with cognitive impairments alone can be detained under the English MHA.

In England, there is a more formal but nevertheless efficient process to enable compulsory inpatients who lack the capacity to instruct a lawyer to receive legal representation. The MHT has a statutory power to appoint a lawyer to represent a person who says they do not want to represent themselves and/or who does not have the capacity to appoint a lawyer directly,²⁰⁴ and will routinely do so in practice:

[T]he Tribunal has committed to making sure it seeks capacity assessments for patients without representation. This should make sure that legal representatives are appointed promptly for patients who are deemed not to have the capacity to decide for themselves whether or not they should have legal representation.²⁰⁵

Lawyers can also directly approach the MHT to seek to be appointed to represent a person who they consider lacks the capacity to formally instruct them, and lawyers are encouraged to do this.²⁰⁶ Therefore, in practice, only people who satisfy the MHT that they are making an informed refusal of legal representation²⁰⁷ will represent themselves before the MHT.

The appointment by the MHT operates as a retainer for the client, but 'does not mean that you are also appointed to act as the client's litigation friend'.²⁰⁸ This means that it is not the appointed lawyer's role to act in the (objective) best interests of the person. The Law Society's practice note describes how the lawyer should carry out their appointed role, with reference to the patient's wishes and feelings and their interest in a fair hearing to determine the lawfulness of their detention (see extract in Appendix 4). The Upper Tribunal has confirmed that lawyers appointed in these circumstances should 'advance all arguable points to test the bases for the detention in hospital',²⁰⁹ unless the lawyer disagrees with the patient's wishes, in which case they should 'advance such arguments as [they] properly can in support of the patient's expressed views'.²¹⁰

Reflections

Barrister/academic Alex Ruck Keene and lawyer Peter Edwards both stated that the people who (are said to) lack capacity and are not asking for help or expressing their concerns are the most in need of advocacy and the most important to help because they otherwise have no voice. Peter noted that failing to facilitate legal representation for a person in this situation on the basis they have not provided instructions is discriminatory; after all, they are not making a capacitous refusal of legal services if they do not understand the consequences.

²⁰³ 22 NYCRR 1200.1.14.

²⁰⁴ *Tribunal Procedure (First-tier Tribunal) Rules 2008* (UK) r 11(7).

²⁰⁵ CQC, *Monitoring the Mental Health Act in 2013/14*, above n 82, 43.

²⁰⁶ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 155.

²⁰⁷ See footnote 162 above.

²⁰⁸ Law Society, *Practice Note*, above n 185, [4.2].

²⁰⁹ *YA v Central and NW London NHS Trusts and Others* [2015] UKUT 37, [103].

²¹⁰ *Ibid* [101].

Victoria falls considerably behind New York and England when it comes to providing legal representation for compulsory inpatients (and many other categories of people) considered to lack the capacity to instruct a lawyer. No statutory provisions exist to facilitate legal representation before the MHT or VCAT²¹¹ for people who lack capacity and there is no 'litigation friend' service.²¹² While a representative of the Public Advocate attends most *Disability Act 2006* (Vic) hearings at VCAT, which at least means that someone independent of the detaining service can test the evidence and make submissions (albeit based on the person's objective best interests rather than their instructions), there is no such function at the MHT.

This means that, when a potential client is unable to provide instructions or adequately indicate their wishes to us, we are unable to provide representation. It is then left to the person to present their own case, despite such people being least able to independently understand the relevant legal issues, marshal evidence and challenge the case against them. More likely, the person will not attend and the hearing will proceed in their absence. This situation is unsatisfactory and arguably a breach of human rights.

Meeting demand for legal representation

The law is not enough: lack of resources for legal representation in Hungary

In Hungary, there is a legal entitlement to representation at each hearing to review the lawfulness and necessity of detention,²¹³ however representation simply does not happen in practice.

Compulsory inpatients have the right to a 'public defender' at every hearing, yet Tamás Verdes, the head of the disability rights program at the Hungarian Civil Liberties Union ('HCLU'), said he was not aware of one ever having actually assisted a person in a psychiatric hospital (he noted that public defenders are paid the equivalent of €3 per day, which provides no incentive for them to do any work).

There are very few lawyers who understand or do mental health and disability rights work in Hungary, which means legal services need to be rationed. Dr Adrienn Gazsi is one of the few lawyers who does this work. She gets calls from all over the country – many people know her personally because she has been doing this work for so long – but, working alone in her legal practice, is unable to travel to villages outside of Budapest to provide representation. Being unable to meet demand, she tries to prioritise court representation in cases that are most likely to benefit others as well (despite Hungarian courts, operating in a civil law system, not being bound by precedents).

The HCLU also provides a small legal service for individuals, which works across all program areas not just disability. They undertake about 10 disability cases at a time, mostly guardianship-related (which in Hungary often means placement in an institution). Aside from case type and merit, they also filter potential cases by strategic potential and, often, the capacity to ultimately take the case to the ECtHR.

Tamás noted that Hungarian lawyers generally know nothing about the human rights significance of guardianship and disability. Moreover, despite supported decision-making being introduced into the new Hungarian Civil Code in 2014, the legal profession seems to remain unaware of it. This means he struggles to find lawyers to provide representation to people outside of Budapest even though there is funding available. The HCLU conducts presentations for law students at universities about these issues in the hope of attracting more lawyers into the area but, while some law students are interested, the profession remains disinterested.²¹⁴ Other efforts to generate interest have fallen similarly flat: Tamás has written to the Hungarian equivalent of the Judicial College three times in the last year regarding training for lawyers and judges about disability law and legal capacity issues, but he has not received any response at all.

²¹¹ The Victorian Civil and Administrative Tribunal. As well as conducting reviews of MHT decisions under the MHA, VCAT has jurisdiction over the civil detention and compulsory treatment of people with intellectual disabilities under the *Disability Act 2006* (Vic) and the disability-specific substituted decision-making regime under the *Guardianship and Administration Act 1986* (Vic).

²¹² The inadequacy of litigation guardian arrangements was reported on by the VLRC: *Guardianship*, above n 8, ch 26.

²¹³ Tamás Verdes.

²¹⁴ Ibid.

‘it’s the court’s responsibility to allocate work and ensure legal representation’.

– Kim Clark, DCPDS MHD, Washington DC

As the situation in Hungary shows, a right to legal representation is meaningless if there is no lawyer who is actually available to provide that representation. However, this was not a problem in either New York or England.

The MHLS has the staff and is sufficiently resourced to be able to represent every patient with a hearing within its mandate, including all CTO matters.²¹⁵ The largest MHLS by far is the Second Department MHLS. It employs about 75 lawyers to cater to a catchment population of 9.1 million, and conducted 3858 hearings in 2014.²¹⁶ While the MHLS is ‘not really’ adequately funded to fulfill all other aspects of its very large and expanding mandate, it ‘certainly do[es]’ fulfill its mandate with regard to all inpatient admissions, discharges and compulsory treatment representations,²¹⁷ including community-based compulsory treatment hearings. The sufficiency of MHLS staffing is protected by statute.²¹⁸

In England, there are over 300 private law firms contracted to do mental health work and over 550 accredited mental health lawyers.²¹⁹ Each quarter, over 10,000 new MHT matters are funded by the Legal Aid Agency, and this figure has on the whole been gradually increasing over the last few years.²²⁰ The Legal Aid Agency spent £49 million on mental health cases in England and Wales in the 12 months to March 2015,²²¹ the majority of which was ‘spent on providing assistance to sectioned clients appealing the terms of their detention before [the MHT]’.²²² While the Legal Aid Agency has a budget for mental health work, it is not set in stone and is sufficiently flexible at the present time to meet demand.²²³ The State’s view that mental health matters have to be funded, even if at the expense of other areas of law, guarantees that demand will be met.

In both New Jersey and Washington DC, demand for the statutory entitlement to legal representation is met through both a primary legal service and private counsel. In New Jersey, the Division of Mental Health Advocacy at the Office of the Public Defender (**‘NJOPD MHA’**), which has 26 lawyers, provides representation in 13 of New Jersey’s 21 counties plus representation to all children in the remaining counties.²²⁴ The remaining counties hire legal services or engage private counsel to ensure patients are represented.

In Washington DC, the Mental Health Division of the Public Defender Service (**‘DCPDS MHD’**), which has ten lawyers, two investigators and one social worker, nominates to the court handling mental health cases how many cases it can take on; there is in fact a statutory cap limiting the number of cases they can take.²²⁵ The DCPDS MHD’s raw number of cases has stayed the same over the years because their fixed resources mean a fixed capacity. However, the proportion of cases they appear in has gone down over time as the number of people subject to civil commitment has increased. They currently handle around 35-40% of all cases and the remaining cases are allocated to a panel of private bar members.²²⁶ Kim Clark, the managing attorney of the DCPDS MHD, said they have never had a real issue with the allocation of cases from the court. Sometimes the court asks if they can take on a few more cases than they originally nominated, and they do, but Kim said the court would also respect their decision if they were adamant and said they could not handle any more: at the end of the day, ‘it’s the court’s responsibility to allocate work and ensure legal representation’.

²¹⁵ Michael Neville, Lisa Volpe.

²¹⁶ Michael Neville.

²¹⁷ Lisa Volpe.

²¹⁸ *Mental Hygiene Law* § 47.01 provides that ‘such staff as may be necessary [to carry out the statutory functions and duties] shall be appointed... by the presiding justice of the appellate division of the judicial department’.

²¹⁹ As at 1 October 2015, there were 561 accredited members on the mental health panel in England and Wales; full list available at <www.lawsociety.org.uk/support-services/accreditation/documents/mental-health-members-list>.

²²⁰ Ministry of Justice (UK), *Legal Aid Statistics*, above n 134, 29.

²²¹ Ibid 23.

²²² Ibid 29.

²²³ Richard Charlton.

²²⁴ Patrick Reilly.

²²⁵ Kim Clark.

²²⁶ The DCPDS MHD trains the panel members, who are paid \$90 per hour for their work. Kim Clark says ‘some are good, some are abysmal’, which drives the DCPDS MHD to take on as many cases as they can.

“Hearings” conducted without such counsel are utterly contrary to the rationales of any coherent, mature system of justice.’

– Emeritus Professor Michael Perlin, New York

Reflections

Again, Victoria is quite out of step with New York and England in its ability to meet demand for legal representation, with legal representation being provided in only 18% of all MHT hearings in 2014-2015.²²⁷

As the tables below show, the total number of mental health legal representations in Victoria almost doubled over the last two years. Net funding for mental health legal services remained unchanged during this time; in particular, no additional funding accompanied the commencement of the new MHA and MHT in 2014. Instead, the increase in representation resulted from VLA's more efficient use of existing funding that was redirected from the broader legal sector into VLA's in-house practice during 2013.²²⁸ As a result, VLA more than doubled its rates of mental health legal representation over the last two years to the point that, in 2014-2015, it provided 93% of all representations before the MHT.

Table 3: Legal representation at mental health hearings by legal service provider (as a proportion of all hearings)

Legal service provider	2012-2013 ²²⁹	2013-2014 ²³⁰	2014-2015 ²³¹
VLA	498 (8.3%)	652 (11.8%)	1101 (17%)
Mental Health Legal Centre ('MHLC')	140 (2.3%)	21 (<1%)	40 (<1%)
Other	35 (<1%)	28 (<1%)	46 (<1%)
Any legal representative	673 (11.2%)	701 (12.7%)	1187 (18%)

Table 4: VLA representation at mental health hearings by hearing type²³²

Hearing type	2012-2013	2013-2014	2014-2015
Inpatient hearings ²³³	498	501	913
CTO hearings	0 ²³⁴	168	184
ECT hearings ²³⁵			47

VLA's ability to represent people before the MHT is capped by its finite staff resources and funding. MHDL's total operating expenditure is just \$3.2 million (which is 2.3% of VLA's overall expenditure).²³⁶ This is used not just for legal advice and representation in relation to mental health hearings but also for matters under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic), the *Guardianship and Administration Act 1986* (Vic) and the *Disability Act 2006* (Vic). With only 15 (12.6 FTE) MHDL lawyers dedicated to this work across the state, plus around six other lawyers contributing to the work on an occasional basis, we are working at the limits of our capacity. Every day we have to make difficult decisions about who is most in need of our assistance and who we cannot personally assist, in the knowledge that anyone turned away will likely struggle to find another lawyer to represent them. With legal representation rates at around 100%, mental health lawyers in New York and England do not face the same dilemma.

²²⁷ MHT (Victoria), 2014/2015 annual report, above n 15, 26.

²²⁸ This resulted in the number of FTE positions in MHDL increasing from 4.6 to 12.6.

²²⁹ Mental Health Review Board, 2013-14 Annual report (2014) 10.

²³⁰ Ibid.

²³¹ MHT (Victoria), 2014/2015 annual report, above n 15, 26.

²³² This table only covers VLA representation because the breakdown of hearing types at which other lawyers appeared is not publicly available. These figures are taken from VLA's internal data.

²³³ The small number of representations for security patients subject to compulsory treatment orders in the high-secure forensic hospital are included in this category.

²³⁴ At this time, there was an arrangement between VLA and the MHLC whereby VLA lawyers would provide representation for inpatients and the MHLC for people on CTOs. Following the redirection of the MHLC's funding to VLA during 2013, VLA lawyers commenced providing some representation for people on CTOs. VLA's data collection did not differentiate between representations for inpatients and those on CTOs until 2014, however the number of CTO representations by provided VLA in 2012-2013 would have been very small.

²³⁵ ECT hearings were only introduced with the new MHA in July 2014 (the Mental Health Review Board, the predecessor of the MHT, did not have jurisdiction over ECT).

²³⁶ VLA, Annual report 2014-15 (2015) 30.

Conclusion

It is hard for a lawyer to protect a person's rights unless they have met the person, are resourced to represent them, and have the necessary instructions or other authority to advocate for decisions and outcomes that will remove or minimise the restrictions on their rights. The jurisdictions I visited had much broader entitlements to legal representation for compulsory inpatients than Victoria: New York directly provided legal representation for every person and England committed to funding representation for practically every person subjected to compulsory mental health treatment, including compulsory treatment in the community. In neither jurisdiction was representation limited by the person's likelihood of success or financial means.

Victoria is out of step with these jurisdictions in terms of both recognising a formal entitlement to legal representation and providing sufficient resources to meet the demand. When informed of the status of legal representation for compulsory inpatients in Victoria, every person I spoke with was surprised. Emeritus Professor Michael Perlin, who was the first director of the NJOPD MHA from 1974 to 1982 and has dedicated himself to this field since that time, was highly concerned:

If the state is to detain people against their will (and to subject them, in many instances to unwanted treatment) in an environment that regularly deprives them of their constitutional civil rights and liberties, it cannot seek to do so without the presence of dedicated, trained counsel.²³⁷ "Hearings" conducted without such counsel are utterly contrary to the rationales of any coherent, mature system of justice. The late Professor Bruce Winick has written eloquently about how the lack of such counsel turns the adversarial process into a "farce and a mockery,"²³⁸ underscoring what I have previously characteri[s]ed as a "basic dishonesty in the civil commitment process"²³⁹...

Our focus must be on the need for *universal* and *effective* representation - *everyone, or at the very least every inpatient*, should have a lawyer in these hearings for multiple reasons: (1) there is no question that the presence of a trained, dedicated, knowledgeable lawyer representing the patient is the single most important factor in the disposition of cases in involuntary civil commitment systems;²⁴⁰ (2) it is only the presence of such counsel that will give life to the "three Vs" – voice, validation and voluntariness – that are the heart of therapeutic jurisprudence,²⁴¹ and (3) there is no disputing the reality that the one constant in the forty years of modern mental disability law has been the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases [if they are not part of a dedicated, specialised legal service] are likely to be ineffective.²⁴² Only the presence of [trained, dedicated, knowledgeable] counsel can give patients an opportunity to present and hear evidence in a meaningful court procedure;²⁴³ the presence of effective counsel leads to better documentation and earlier staffing and "a greater tendency [on the part of the hospital] to release patients... in cases where the case for committability appears to be marginal."²⁴⁴ Only the presence of such counsel will likely lead to the retention of independent experts so as to most optimally enhance the treatment provider's attention to and familiarity with the patient in question²⁴⁵ (emphasis and citations in original).

When asked whether his opinion was contingent on an adversarial hearing process and would be different in respect of more informal, inquisitorial hearings, Michael was clear:

I believe that in any proceeding in which liberty might be lost (or there is any potential "consequence of magnitude"... there must be counsel. Period... The fact that the hearing is inquisitorial is inconsequential to me. The person can get locked up against her will. As far as I am concerned, that is game/set/match.

Formal legal rights aside, it is important to understand what having a lawyer – compared to having to represent yourself – means to the person at the centre of the hearing. For instance, English service user Ian Callaghan said he felt it was essential to have the help of a lawyer at every MHT hearing:

I think most people would always want a lawyer present and can't imagine many people would want to represent themselves. Representing yourself is hard enough in ward rounds and [care planning] meetings, let alone in a Tribunal!

²³⁷

See generally Perlin and Cucolo, above n 178, ch 6 and especially § 6-4.2.

²³⁸

Bruce J Winick, 'Therapeutic Jurisprudence and the Civil Commitment Hearing' (1999) 10 *Journal of Contemporary Legal Issues* 37, 41.

²³⁹

Michael L Perlin, "'Half-Wracked Prejudice Leaped Forth': Sanism, Pretextuality, and Why and How Mental Disability Law Developed As It Did' (1999) 10 *Journal of Contemporary Legal Issues* 3, 26.

²⁴⁰

Michael L Perlin, "'You Have Discussed Lepers and Crooks': Sanism in Clinical Teaching' (2003) 9 *Clinical Law Review* 683, 688.

²⁴¹

Juan Ramirez Jr and Amy Ronner, 'Voiceless Billy Budd: Melville's Tribute to the Sixth Amendment' (2004) 41(1) *California Western Law Review* 103, 119.

²⁴²

Michael L Perlin, "'I Might Need a Good Lawyer, Could Be Your Funeral, My Trial': A Global Perspective on the Right to Counsel in Civil Commitment Cases, and Its Implications for Clinical Legal Education' (2008) 28 *Washington University Journal of Law and Policy* 241, 241.

²⁴³

Michael L Perlin, "'And My Best Friend, My Doctor/ Won't Even Say What It Is I've Got': The Role and Significance of Counsel in Right to Refuse Treatment Cases' (2005) 42 *San Diego Law Review* 735, 742, discussing John J Ensminger and Thomas D Liguori, 'The Therapeutic Significance of the Civil Commitment Hearing: An Unexplored Potential' (1978) 6(1) *Journal of Psychiatry and Law* 5, 15-19.

²⁴⁴

Ensminger and Liguori, above n 243, 20.

²⁴⁵

Ibid 17.

Victoria must acknowledge that subjecting people to deprivations of liberty and other significant restrictions on their human rights without providing adequate access to legal representation is significant issue. These restrictions on rights are arguably not justified or permissible if the fundamental balancing safeguards and protections – including periodic, fair hearings – are not (practically) in place. By failing to provide sufficient resources to facilitate legal representation for those who require representation in accordance with human rights principles, the State is enabling potentially unfair hearings and thus potentially unlawful deprivations of liberty. The simplest and most effective way to address this would be for the State to provide additional funding to increase the availability of MHT legal representation.

Unless or until that occurs, the MHT should give real consideration to declining to conduct hearings without legal representation if the resultant hearing would be unfair, and thereby end the restrictions on the person. The question of whether an MHT hearing conducted in the absence of legal representation is, at least in certain circumstances, unfair and therefore an inadequate safeguard against the arbitrary deprivation of liberty has not yet been litigated in Victoria, at least not since the commencement of the Charter. It remains to be seen how Victorian courts would respond to such a challenge because international human rights jurisprudence does not directly translate to our context. For one thing, although Victoria's Charter contains a similar provision to art 5(4) of the *Human Rights Act 1998* (UK) and the ECHR,²⁴⁶ the ability to seek an MHT hearing does not even fulfil this right as the MHT is not a 'court' as defined in the Charter, an issue which does not seem to have been confronted yet.

Either way, it falls to the State to provide a solution to this situation.

RECOMMENDATIONS AND IDEAS

- ▶ Request the State provide adequate funding for MHT legal representation in all matters where representation forms part of the safeguards necessary to render the detention and compulsory treatment permissible under human rights law.
 - Collaboratively plan how to engage with the State on this issue.
- ▶ In order to plan a response and inform negotiations with its funders, VLA should examine the cost of providing legal representation to all people who should be entitled to legal representation in accordance with human rights principles.
- ▶ Noting its obligations as a public authority under s 38(1) of the Charter to give proper consideration to relevant human rights when making decisions, VLA should consider if there is any scope within existing funding constraints to expand eligibility for duty lawyer services and/or grants of legal assistance for MHT representation, to better facilitate legal representation for people who would be unable to obtain a fair hearing without it.
- ▶ Encourage the MHT to establish a protocol:
 - Requiring members to enquire of all non-attending and unrepresented persons whether they would like legal assistance and to adjourn the hearing for that purpose if they choose;
 - Setting out the circumstances in which it would decline to conduct a hearing if legal representation is unavailable and as a result a fair hearing cannot be conducted.
- ▶ Consider how legal assistance may be provided to people with hearings before the MHT who lack the capacity to formally instruct a lawyer.
- ▶ Consider whether it may be appropriate for IMHA to support people unable or unwilling to engage a lawyer to express their views to the MHT.

²⁴⁶ Section 21(7) of the Charter provides that 'any person deprived of liberty by arrest or detention is entitled to apply to a court for a declaration or order regarding the lawfulness of his or her detention'.

3B. PROTECTING RIGHTS IN JUDICIAL CONTEXTS: MENTAL HEALTH COURTS AND TRIBUNALS

How are judicial decision-makers relevant to rights protection?

In this report, the term ‘**judicial decision-maker**’ is used to refer to the person or people who are tasked with determining the outcome at a mental health hearing even though, in a strict legal sense, they may be exercising administrative power. In New York, the judicial decision-maker is a Supreme Court judge. In England and Victoria, a tripartite panel of tribunal members constitutes the judicial decision-maker.

As noted above, mental health hearings are an essential rights safeguard in a system of compulsory mental health treatment because they provide an opportunity for independent scrutiny of the necessity and appropriateness of detention, compulsory treatment and other rights restrictions. If, at the hearing, the statutory legal criteria for those interventions are not found to be met, the person must be released. Accordingly, these hearings are very powerful.

Lawyers help to protect their clients’ rights at mental health hearings by:

- Listening, seeking instructions and providing information and advice;
- Acting on their instructions (rather than in their perceived ‘best interests’);
- Reframing their instructions and wishes into a legal position and argument that the judicial decision-maker will understand;
- Supporting them to directly participate in the hearing to make sure their wishes and voice are heard;
- Scrutinising and challenging the evidence presented in support of restrictions;
- Gathering and adducing evidence in support of their client’s position;
- Presenting reasoned submissions for the removal or reduction of the restrictions on their rights and/or for an increase in freedoms (such as access to rehabilitation and community activities);
- Working to ensure that the hearing is conducted fairly; and
- Scrutinising any decision permitting ongoing rights restrictions to make sure it is based on cogent evidence and a correct interpretation and application of the law (including being as minimally restrictive as possible), and appealing that decision if not.

At the IALMH conference in Vienna, Maria Bisogni, the deputy president of the NSW Mental Health Review Tribunal, spoke about the ‘pivotal role’ that lawyers play in mental health hearings, maximising their clients’ participation and helping their clients raise and frame issues before the Tribunal.²⁴⁷ She also referred to research²⁴⁸ that shows a sense of fair process in arriving at the conclusion renders the decision – even if ultimately restrictive – more acceptable to the patient, which also increases the likelihood they will abide by it.

However, the efficacy of legal representation and a lawyer’s attempts to protect their clients’ rights are significantly impacted by the court process and the attitudes and approach of the judicial decision-makers. The different processes and approaches taken by the Supreme Court in New York and the MHT in England highlight just how much lawyers are subject to these vagaries in attempting to fulfil their functions. Therefore, in order to be effective, lawyers must understand who and what influences these processes and attitudes and find effective ways to advocate and influence the judicial decision-makers to best ensure the protection of their clients’ rights.

In conducting this part of the research, I explored:

- What variables impact directly on rights and/or a lawyer’s ability to protect their clients’ rights in mental health hearings;
- How lawyers respond and act to protect their clients’ rights at mental health hearings; and
- Whether people thought that judicial decision-makers and mental health hearings in their jurisdiction were rights-respecting and, if so, what they thought were the most significant factors contributing to this.

²⁴⁷

‘Legal representation in mental health hearings in New South Wales, Australia’ (presentation at the IALMH conference, Vienna, July 2015).

²⁴⁸

Research on this issue includes: Tom R Tyler, ‘The Psychological Consequences of Judicial Procedures: Implications For Civil Commitment Hearings’ (1992) 46 *Southern Methodist University Law Review* 433, 444 (discussing therapeutic value of judicial civil commitment hearings, and stressing that individuals benefit from hearings in which they can take part, are treated with dignity, and are ‘fair’); Nourit Zimmerman and Tom R Tyler, ‘Between Access to Counsel and Access to Justice: A Psychological Perspective’ (2009) 37(1) *Fordham Urban Law Journal* 473; Bruce J Winick, *Civil Commitment: A therapeutic jurisprudence model* (Carolina Academic Press, 2005) 156, 145-149.

Key variables impacting on rights and/or a lawyer's ability to protect rights in mental health hearings

Two key prerequisites for lawyers to be able to protect rights in mental health hearings have already been discussed in Part 3A above – whether and how clients are referred to them and whether the person is entitled to legal representation at the hearing. In this section, I examine some further variables that specifically impact on rights and/or the lawyer's ability to protect their clients' rights in mental health hearings. How lawyers respond to these factors and act to best protect their clients' rights is then discussed in the section below.

Notice of hearings and prior access to information

Whether and when a person and their lawyer are notified of a mental health hearing and can access relevant information about it will have a significant bearing on how well they can prepare for that hearing, which in turn is likely to impact on their ability to influence the proceedings and outcome. While MHLS lawyers in New York have no difficulty finding out about scheduled hearings because of their clear mandate to appear at each hearing, England appears to have far stronger mechanisms to ensure that lawyers are provided with relevant information in a timely fashion.

In New York, where a hearing is initiated by the hospital, the MHLS will usually find out about three to four business days beforehand that a patient has a hearing scheduled. The hearings centre on oral testimony rather than previously-prepared reports or written evidence. Therefore, in order to understand the clinician's perspective and anticipate the evidence they are likely to give at the hearing, MHLS lawyers have to talk with their client, use their statutory powers to access and read their client's clinical file and talk with staff to obtain information.

In contrast, English mental health services are required to prepare and disclose reports well prior to the hearing. At 19 pages, the MHT's direction on statements and reports in mental health cases²⁴⁹ is detailed and prescriptive. In addition to a statement of information about the patient, the mental health service is required to provide three separate reports in respect of a compulsory inpatient – a responsible clinician's report, a nursing report and a social circumstances report – to ensure a breadth of information and perspectives beyond symptomatology and clinical opinion. Reports for section 2 patient hearings (which take place within 21 days of the patient's admission and with only up to seven days' notice of the hearing) must be provided 'as soon as practicable'. Reports for the more common section 3 patient hearings must be provided 'as soon as practicable and in any event within three weeks after' the hearing was triggered, which means a minimum of two weeks before the hearing date.

Recognising that the early provision of reports is necessary to ensure adequate preparation and thus necessary for a fair and timely hearing, the MHT now takes an active role in enforcing compliance with the provision of these reports. Research gathered between January and March 2015 revealed that 18.3% of reports were received late (ie less than two weeks before the hearing).²⁵⁰ In April 2015, the Chief Judge of the MHT sent a strongly-worded letter to all MHA administrators²⁵¹ to outline its new system for enforcing compliance, which includes referring any non-complying report-writers or hospital Chief Executives to the Upper Tribunal for consideration of penalties for contempt:

The [MHT] is looking to reduce the time it spends chasing after the Responsible Authority's written evidence (i.e. reports and 'Statement of Information') whilst, at the same time, adopting an efficient slimmed-down procedure that provides an effective sanction for non-compliance and which is more immediate, proportionate and focused than immediately summoning witnesses, Chief Executives or Medical Directors...

The legal duty to provide reports etc is placed firmly at the door of the Responsible Authority, but we recognise that some MHA Administrators find it difficult to enforce compliance... Our intention is to send a specific direction to the identified person who has failed to submit their report or statement, requiring that their written evidence be submitted within 7 days, with a warning that if this direction is not complied with, we will consider referring the person to the Upper Tribunal for consideration of a penalty...

I need to stress that, if a referral is made, the Upper Tribunal has power to punish what amounts, in effect, to a contempt of court.²⁵²

249

First-Tier Tribunal, Health Education And Social Care Chamber, *Practice Direction: Statements And Reports In Mental Health Cases*, 28 October 2013.

250

Nicholas Hallett, 'Improving the quality of medical reports for Mental Health Tribunals', *Psychiatry, Psychology and Law* (published online 1 September 2015) 1, 2.

251

See 'MHA administrators' in Part 3C below.

252

Full letter available at <http://www.mentalhealthlaw.co.uk/Tribunal_Procedure:_Failure_to_submit_reports_to_the_tribunal_on_time_%2817_April_2015%29_%282015%29_MHLO_38>.

253

Richard Charlton.

254

Hallett, above n 250, 4.

255

Mental Health Tribunal Rules 2014 (Vic) r 12(1).

256

Ibid r 14: 'A clinical report referred to in rule 13 must contain the following—

- (a) 'information on the relevant clinical and personal background of the person who is the subject of the proceeding;
- (b) 'if the psychiatrist or authorised psychiatrist is required to be satisfied as to certain matters under the Act, the reasons as to why the psychiatrist or authorised psychiatrist is so satisfied;
- (c) 'particulars of the treatment currently provided to the person who is the subject of the proceeding;
- (d) 'particulars of the treatment which the authorised psychiatrist proposes to provide to the person who is the subject of the proceeding;
- (e) 'any advance statement of the person who is the subject of the proceeding;
- (f) 'any second psychiatric opinion with respect to the person who is the subject of the proceeding;
- (g) 'the views and preferences of the person who is the subject of the proceeding;
- (h) 'if required under the Act, the views and preferences of the following persons with respect to the person who is the subject of the proceeding—
 - (i) 'the nominated person;
 - (ii) 'a guardian;
 - (iii) 'a carer;
 - (iv) 'a parent, if the person is under the age of 16 years;
 - (v) 'the Secretary to the Department of Human Services.'

While hospitals were initially very unhappy with the aggressive stance which the MHT is taking on this, they are now largely compliant.²⁵³ Peter Edwards' staff said that, if a report is provided late, the author would 'get seriously ticked off' by the MHT.

John O'Donnell said that the quality of reports which services prepare for the MHT is mostly good, although some are 'dreadful' (which is more likely to be the case in city hospitals and where locums are used). In a 2015 study by Nicholas Hallett, the MHT panel rated over 93% of reports as being either adequate (-24%), good (-52%) or excellent (-18%) in assisting them to reach a decision on the statutory criteria.²⁵⁴

Comparison with Victoria

In Victoria, a psychiatrist must provide a 'clinical report' to the MHT in respect of any hearing.²⁵⁵ Reports must be in the prescribed template and address certain matters.²⁵⁶ The reports must be provided 'as soon as is reasonably practicable or otherwise as directed by the Tribunal'.²⁵⁷

The *Mental Health Act 2014* (Vic) provides that any document 'in connection with [a] proceeding' (which includes such reports) must be provided to the patient and their legal representative 'at least 48 hours before the hearing'.²⁵⁸ However, compliance with this requirement varies significantly between services and many services provide reports only late in the afternoon before or even on the day of the hearing. In MHDL's experience, the tolerant attitude of some MHT members towards even routine non-compliance by services does little to encourage their compliance in this regard.

In addition, the Victorian MHT does not provide a minimum amount of notice to patients of their hearings, and notice is not always provided in writing.²⁵⁹ Accordingly, many hearings take place in circumstances where patients and their lawyers have been disadvantaged in their ability to prepare for the hearing due to non-compliance by services with their information disclosure obligations and/or short notice periods. Where a procedurally fair hearing cannot be conducted, the MHT's guidance material directs members to adjourn the hearing where possible rather than dismiss the service's application or decline to make a compulsory treatment order,²⁶⁰ which has the effect of continuing the restrictions on the person and delaying their opportunity for release. In our experience, it is exceedingly rare for the MHT to dismiss the service's application or decline to make a compulsory treatment order where a procedurally fair hearing cannot be conducted. Furthermore, even though an adjournment can only be granted beyond what would otherwise have been the expiry of an order in 'exceptional circumstances',²⁶¹ the MHT did this on 212 occasions in 2014-2015 (26% of which were because the service was not ready to proceed),²⁶² and a further 109 occasions in the first quarter of 2015-2016 alone.²⁶³ However, patients will often decide to proceed with the hearing rather than seek an adjournment on the basis of procedural fairness concerns because adjourning would delay their opportunity for release (usually by between one and two weeks).

Pace and depth of hearings

The varying levels of engagement and proactive inquiry by the judicial decision-makers – and the time permitted for the hearing – significantly impact on how lawyers provide advocacy on behalf of their clients.

Mental health hearings in New York are very quick and conducted as part of a busy list, rather like a mentions court. On the day I observed hearings at BPC, the court had been conducting hearings at another hospital that morning and so commenced sitting at BPC at 12pm. The judge announced upfront that she wanted to finish by 2:30pm. Twenty-nine matters were listed. Following a call-over, at which various matters were adjourned or withdrawn due to the patients having been discharged, eight matters were identified to proceed to hearing. Although the court sat until 3pm despite the judge's intention to finish earlier, it only heard three substantive matters and adjourned the remainder due to lack of time, which was apparently not uncommon. Hearings conducted at the patient's request are given priority to proceed, as are matters where the person is not expected to be held in hospital for long. 'Treatment over objection' applications²⁶⁴ are the lowest priority and most likely to be adjourned, which pleases patients because they cannot be medicated against their wishes until the court has approved the contested treatment at a hearing.

²⁵⁷ MHT (Victoria), *Practice Note 1: Tribunal Documents (Application Forms, Urgent Applications And Clinical Report Templates) And Attendance Requirements*, 1 July 2014, [21].

²⁵⁸ *Mental Health Act 2014* (Vic) s 191(1).

²⁵⁹ MHT (Victoria), *2014/2015 annual report*, above n 15, 11. This is particularly the case with applications for ECT, where 49% of hearings are conducted within one day of the MHT receiving the application (necessarily meaning less than one day's notice for the patient concerned), 70% within two days and 84% within three days (at 21), despite the service not asserting any urgency in just over half of the applications. The MHT's approach to listing ECT applications makes it impossible for the service to comply with its statutory obligation to disclose relevant information to the patient at least 48 hours before the hearings (*Mental Health Act 2014* (Vic) s 184(1)), let alone permit sufficient time for the patient to seek legal advice, organise legal representation or generally prepare. VLA endeavours to appear in all ECT hearings where a patient seeks our assistance, yet we were only notified and could appear in 7% of all ECT hearings in 2014-2015. Given that approval for ECT is granted at much lower rates (44%) when a VLA legal representative appears before the MHT compared to where a patient is unrepresented (89% of all ECT applications are granted: MHT (Victoria), *2014/2015 annual report*, above n 15, 20), the very low rates of legal representation in ECT hearings is concerning.

²⁶⁰ MHT (Victoria), *A Guide to Procedural Fairness in the Mental Health Tribunal* (2014) 5.

²⁶¹ *Mental Health Act 2014* (Vic) s 192.

²⁶² MHT (Victoria), *2014/2015 annual report*, above n 15, 25. In 49% of all adjournments, the length of the treatment order was extended.

²⁶³ MHT (Victoria), *Performance against Key Performance Indicators, 1 July to 30 September 2015* (2015) 1.

²⁶⁴ See 'Direct participation in formal 'treatment over objection' processes: New York' in Part 3C below.

I found the detail of evidence given and the level of scrutiny seen to be applied to it by the judge was considerably less in New York than in England. The Attorney-General's representative led the clinicians through their evidence in a fairly formulaic fashion, largely just getting them to provide their opinion as to whether each statutory requirement was met ('Would you say [criteria A]? Yes'). There seemed to be comparatively little detail about the person, their specific symptoms, how they came to be in hospital and how their presentation has changed, and no real detail about their interaction with staff and attitude towards medication. They only referred to specific incidents occasionally. However, on occasion the judge would interrupt the evidence-in-chief to demand detail about overly general comments ('Touching people - how, where, in what way?'; 'Provoked other patients - how, what did he say?').

Furthermore, in the hearings I observed, the judges did not provide reasons of any real substance when giving their decisions, simply, 'The court has heard clear and compelling evidence that [restated the criteria] and so the application for release is denied'. It was accordingly impossible to assess how the judge had actually weighed up the evidence.

In contrast, as a result of not conducting more than two oral hearings a day, the English MHT members are not – and importantly do not present as – rushed, and do not cut short exploration of relevant issues due to time pressures. A 2003 study found the average time of an MHT hearing was 75 minutes,²⁶⁵ which was slightly shorter than the hearings I observed. In addition to requiring three reports, the MHT expects the author of each report to attend the hearing to speak to their report and be cross-examined. If someone stands in for the report author, they will be expected to have met the client and have some familiarity with them, otherwise the matter would likely be adjourned.²⁶⁶ Adjournments in these circumstances are only for a few days.²⁶⁷ At one hearing I observed, no-one representing the social circumstances report was present (the report's author was on leave and the organised replacement had an unexpected family emergency that day). The MHT only proceeded with the hearing after the lawyer, on her client's instructions, strongly advocated for the hearing to proceed.

In the English hearings I observed, which I was told were typical, the MHT members each played a very active, inquisitorial role. It was clear from the comments and questions at the commencement of the hearing that they had closely read all of the material provided to them (for instance, they highlighted at the outset internal inconsistencies and errors which would only have been apparent after close reading and cross-referencing of reports). After each report author presented their report, each MHT member then questioned them in turn, drilling down to clarify what (if any) evidence supported a particular assertion or whether it was merely inference or supposition. The MHT members did not lead the witnesses to make out their case and made it clear they expected the witness to bring evidence to convince them why the patient should not be discharged. The patient's lawyer only questioned the authors after each of the three MHT members had, which meant the lawyer only needed to ask comparatively few questions because the MHT had been so thorough. As a result, the process felt robust but not adversarial.

While English MHT judges are appointed on aptitude not subject-matter experience,²⁶⁸ many of the judges appointed are experienced mental health lawyers, who continue to practice as solicitors or barristers during their appointments. They all complete a three-day residential training course prior to commencing in their roles.²⁶⁹ During the hearings I observed, the MHT members demonstrated a thorough understanding of the law and proactively identified and were willing to discuss legal issues as they arose. A case name needed only to be mentioned for the members to nod in understanding, as they seemed familiar with them. Members also proactively referenced specific standards in the Code of Practice²⁷⁰ when questioning the service representatives.

Fixed or rotating decision-makers

Whether the judicial decision-makers conducting mental health hearings are regular and fixed or varied from hearing to hearing has a real impact on both how the hearings are conducted and the lawyer's advocacy.

In New York, a particular judge is appointed to conduct mental health hearings at a particular location for a lengthy period of time.²⁷¹ As was apparent even from my short observations, when the same lawyers appear before the same judge time after time, particular patterns and short-hands emerge in both procedure and verbal exchanges between them. While these are efficient for the lawyers and judge, they are likely to be confusing and inaccessible to any new participant, including the patient, which hinders their ability to follow what is going on.

²⁶⁵ Elizabeth Perkins, *Decision-Making in Mental Health Review Tribunals* (Policy Studies Institute, 2003) 53.

²⁶⁶ Peter Edwards' staff.

²⁶⁷ Ibid.

²⁶⁸ (anonymous).

²⁶⁹ (anonymous).

²⁷⁰ See 'Code of Practice' in Part 3C below.

²⁷¹ This may range from a couple of months to years, depending on the county.

‘on the whole [the MHT] approach[es] cases with an open mind’ rather than simply as a ‘rubber stamp’ for whatever the treating team wants.

– English service user Ian Callaghan

Furthermore, while each person deserves to have their case put and explored in full, by reading the codes and conventions, lawyers learn when to abandon particular arguments or stop pushing a point before a particular judge. After all, it is infuriating, futile and probably counterproductive to try to make the same argument week after week to the same judge. Tina Minkowitz noted this during her intensive, five month monitoring study of mental health hearings in Brooklyn in 1997, and also that having a fresh judge led to a fresh approach:²⁷²

[W]hen attorneys do represent their clients’ asserted position, they are usually stymied by the court... [However] before a judge who is not accustomed to the [*Mental Hygiene Law*], attorneys will make a greater effort to establish a fresh perspective.

The primary recommendation in her report was therefore a ‘rotation of judges in the Mental Hygiene Part [of the Supreme Court] to provide a better chance of a fair hearing’.

In contrast, the MHT members in England sit as a panel of three, reducing the individual impact or influence of any one member. Sitting as they do in random rather than routine combinations also permits a ‘fresh’ approach by the lawyers appearing before them in each hearing. The wider range of lawyers appearing before the MHT in any given location would also guard against hearings becoming too routine.

Comparison with Victoria

In Victoria, the MHT also typically sits as a panel of three members. Two positions will be randomly filled from the pool of appointed members but one position will be filled by a member assigned to the particular location for six months at a time. As the approach and influence of the individual members vary considerably, MHDL has found that having fixed sitting members can significantly alter the nature of hearings between locations.

Influence of psychiatrists

How much a lawyer and legal arguments can persuade the judicial decision-maker at a mental health hearing is also limited by how deferential to and/or accepting of psychiatric evidence the decision-maker is.

In New York, the sole decision-maker is a judge, with significant legal but no particular clinical training or experience. This factor, combined with the judge’s personal attitude towards psychiatry, may cause them to either apply shrewd scrutiny to the psychiatrist’s evidence from a position outside the medical model, or alternatively to be uncritically deferential to it. The judges I observed tended towards the latter, though I was told that not all judges are like that.

In England, service user Ian Callaghan felt that ‘on the whole [the MHT] approach[es] cases with an open mind’ rather than simply as a ‘rubber stamp’ for whatever the treating team wants:

They do often go with what the clinical team say, as they acknowledge that they probably know the person best, but as you always see an independent doctor,²⁷³ this could be overruled. However, I think it’s probably unusual for this to completely contradict what the person’s doctor has recommended, but I’ve certainly known this to be the case.

²⁷² Mental Hygiene Law Court Monitoring Project: Part 1 of Report: Do Psychiatric Inmates in New York Have the Right to Refuse Drugs? An Examination of Rivers Hearings in the Brooklyn Court (1997).

²⁷³ As explained under ‘Hearings before the English Mental Health Tribunal’ in Part 2B above, the psychiatrist member will often meet with and examine the person prior to the hearing, which produces separate psychiatric evidence to that provided by the treating psychiatrist.

Laura Wilson, a lawyer who works for John O'Donnell, said that the MHT still gives a lot of deference to the evidence of the treating psychiatrist. Peter Edwards' staff also sensed that the psychiatrist can be disproportionately influential, particularly where the legal member is less familiar with the jurisdiction. Laura said the treating psychiatrists can be very frustrating when giving evidence. In one hearing I observed, the psychiatrist gave evasive answers to questions from the MHT members. His evidence included a number of unsubstantiated opinions that were exaggerated and misleading (for instance, he significantly underestimated the period of time over which certain positive behaviours had been observed when compared to the clinical file notes) and he refused to concede seemingly obvious points (such as the contributory impact of alcohol on the patient's behaviour). He also evidenced a limited familiarity with his patient (for instance, nominating the patient's mother as his nearest relative despite the patient's mother in fact being deceased). However, in another hearing I observed, the psychiatrist willingly gave detailed and considered evidence, provided specific examples and made concessions where appropriate. There is clearly variability in how psychiatrists approach their role in giving evidence. For the most part, as noted above, I thought the MHT was quite good at probing the psychiatrists' evidence.

While the patient's primary nurse in England is required to write a separate report and give their own evidence, a number of people told me that they will usually just defer to the position of the psychiatrist in the hearing, even if outside the hearing they are supportive of a different position.²⁷⁴ One nurse even said during her evidence in a hearing I observed that she 'had to follow what the psychiatrist said'. The MHT assured her that they were interested in her own opinion.

Aside from the influence of psychiatrist witnesses, the medical member of the MHT is also in a powerful position. As noted under 'Hearings before the English Mental Health Tribunal' in Part 2B above, the medical member will usually meet with and examine the person prior to the hearing, which produces separate psychiatric evidence to that provided by the treating psychiatrist. In a 2011 report on patient experiences, patients who had been pre-interviewed by the medical member 'gave very mixed reviews of th[is] process'.²⁷⁵

They described very different approaches to questioning from medical members, with some asking questions about all aspects of patients' lives and others focusing on only one or two issues, and many felt the interviews were too rushed.

The dual role of the medical member as 'clinician and legal actor, and as witness and decision-maker', was noted as a concern by Dr Amar Shah.²⁷⁶ Previous studies have also shown that the opinions of medical members carry disproportionate influence.²⁷⁷

This factor has also been noted in the Australian context:

Particular sensitivity arises around sharing of views between members prior to the hearing and during tribunal deliberations, such as when medical members provide other members with 'an interpretive framework' or lens for interpreting the patient's evidence before the hearing. This is problematic in that the interpretive lens may have 'served to discount what the patient would say during the hearing'.²⁷⁸

Respect for and engagement with the person at the centre of the hearing

One measure of whether a mental health hearing process is rights-respecting is whether the person themselves is able to participate in the hearing. A further measure is whether the judicial decision-maker treats them with respect and makes reasonable accommodations to facilitate their engagement.

In New York, patients are far less central or involved in their hearings than in England. Although they sit next to their lawyer at the bar table rather than behind them (as they would in typical court proceedings), they will only speak if their lawyer calls them to give evidence, and the judge will not speak to or question them directly unless they are so called.

²⁷⁴ Laura Wilson, Peter Edwards' staff.

²⁷⁵ CQC and Administrative Justice and Tribunals Council, above n 159, 5.

²⁷⁶ Shah, above n 118, 28.

²⁷⁷ Eg Perkins, above n 265, 124; Genevra Richardson and David Machin, 'Doctors on Tribunals: A confusion of roles' (2000) 176(2) *British Journal of Psychiatry* 110.

²⁷⁸ Terry Carney, David Tait, Duncan Chappell and Fleur Beaupert, '"TJ" implications of weighing fairness, freedom, protection and treatment' (paper presented at the 3rd International Conference on Therapeutic Jurisprudence, Perth, June 2006), quoting Perkins, above n 265, 46.

I was told that the judge sitting at BPC did not have a great deal of empathy for the patients and was currently fixated on security following an incident a few months earlier when a patient broke a glass window after a hearing. As a result, there were multiple court and hospital security officers present in the court room on the day I attended. An MHLS client, who began pacing in the corridor outside the courtroom after waiting a few hours for his matter to be called, was put in handcuffs because this was seen as a security concern. When the MHLS lawyer explained the situation and asked for the matter to be called on, the judge queried whether it would be safe enough for the handcuffs to be removed. Frustrated, the lawyer replied, 'There are six security staff your Honour, you're not in any danger'.

This security concern had also influenced other processes in the BPC hearings. For instance, the court had taken to 'deferring' judgment, which meant at the conclusion of submissions the patient had to leave the hearing room. The judge then immediately delivered judgment in the person's absence, leaving it to the lawyer to tell their client what had happened afterwards. The MHLS lawyers were scathing of this disrespectful approach which denies people the right to observe their hearing in full.

The court did not seem conscious of the impact that its approach may have on patients and their families. An exchange during one of the hearings at BPC troubled me. The judge was questioning the patient about why he did not eat the food his parents had brought to him in hospital (after it had already been established in open court that he thought they were poisoning his food before he came into hospital and had paranoia). After a long pause during which the client looked conflicted, the judge said that it was really important that he answered her questions because, if he wanted to get out of hospital, she needed the information to make a decision. When he turned around to look at his parents and sister, who were sitting in the body of the court, the judge said, 'Don't worry about them, it doesn't matter what they think'. He finally said, 'I don't love them anymore'. She kept pressing, asking why he didn't love them anymore. Again, there was a lengthy pause and finally, looking distressed, he said, 'I don't think they have my best interests at heart'. There did not seem to be a need to press this far. The public nature of New York mental health hearings also meant that the family could not be asked to leave in order for the person to be able to give his honest evidence in private.

In total contrast, English MHT hearings are very patient-centred. Prior to the hearing, the MHT proactively seeks relevant information to ensure it is in a position to be able to conduct a fair hearing. For instance, amongst numerous other things, the author of each report provided to the MHT is required to state:

whether there are any factors that may affect the patient's understanding or ability to cope with a hearing and whether there are any adjustments that the tribunal may consider in order to deal with the case fairly and justly.²⁷⁹

At the hearing, the person sits at the centre of the (single) table, directly across from the MHT members, with their lawyer and clinical team on either side. The MHT members I observed in action were very respectful towards the patients and conscious of the impact of the hearing environment on them throughout the hearings. The MHT engaged directly with the patient at the commencement of each hearing. One judge commenced the hearing for a Welsh-speaking patient in Welsh to put her at ease and was at pains to acknowledge how difficult it must be to be detained in an environment where your first language is not spoken (the patient told me afterwards that the judge had 'schoolgirl' Welsh but was nevertheless appreciative of the effort). The members were also very clear when explaining their function at the commencement of the hearings and stated to the patients upfront that they were there to listen to the evidence and would only keep them on the order if the service presented sufficient evidence to convince them that the criteria were met; they placed the burden squarely on the hospitals. They stressed that there was no expectation or requirement on the patient to 'defend' themselves or present any evidence. At the conclusion of each hearing I saw, the MHT judge took a moment to reflect on the positives and the patient's progress, either before or after delivering the decision.

The Victorian MHT is far closer in its processes and engagement with patients to the English MHT than to the New York Supreme Court.

²⁷⁹ First-Tier Tribunal, *Practice Direction*, above n 249, 4.

Judicial attitudes towards legal representatives and respect for the lawyer's role

The degree to which the judicial decision-makers understand and are respectful of the lawyer's role at mental health hearings influences the extent to which the lawyer will be given the opportunity to participate meaningfully in those proceedings. It will also influence whether the decision-maker genuinely listens to what the lawyer is submitting on their client's behalf and is open to persuasion rather than simply going through the motions.

The New York Court of Appeals has recognised that the MHLS is essential to the 'protective shield of checks and balances'²⁸⁰ against the detention and provision of compulsory treatment to people diagnosed with mental illness. On the ground however, Sara Rollyson said that the MHLS' mandated role does not automatically bring with it a level of respect or even appreciation from the judges. However, over time she feels they earn the judges' respect:

I think we do earn the judges' respect because they realise that it's not an easy job... We know the law, we know the charts better than the doctors, we know our cases, so we really try to put on a good case for everybody. So they respect us in the end, they might not agree with us but they respect us in the end...

There is one judge in particular there who made comments to us, 'Why do you even bother doing this?' but that was a one-off so we didn't really have time to build [a response to] it. [Our attitude is,] 'This is our job and we are mandated to be here, we are not here to disrespect you'.

In the BPC hearings, there was heated argument not just between the opposing lawyers but also between an MHLS lawyer and the judge. At one point, when the MHLS lawyer repeatedly pressed a point which the judge appeared not to have understood but had already ruled on, they kept speaking over each other until the judge threatened her with contempt. Nevertheless, the court seemed very accepting of the role that lawyers play in these hearings. I did not otherwise see any lawyers being cut off from cross-examining the doctors, presenting their case or making submissions. The knowledge by judges that they are being recorded, and can and will be appealed, no doubt restrains judicial comment and behaviour so as to at least ensure the appearance of fairness throughout the hearing.

One person I spoke with, who has participated in mental health legal services in both jurisdictions, felt that lawyers were not treated with as much respect in New York compared to lawyers before the MHT in England. This person felt the court's more limited respect for lawyers drives a type of adversarialism in the lawyers against the court – a desire to push back harder and win – that was not present among English lawyers, although this person was not sure how much this was simply a cultural difference in advocacy styles.

Mental health law is taken seriously by courts in England, which in turn have recognised the complexity and importance of the work which mental health lawyers do. For instance, in 2000, Lord Justice Brooke of the High Court commented (in relation to changes to the Legal Aid Agency funding arrangements):

Mental health law is difficult enough today. Reading the report of a psychiatrist, identifying its areas of weakness, commissioning evidence from the appropriate expert to challenge it, and representing a client at a tribunal requires expert professional skills born... of education and practical experience. It is not like going down to the magistrates' court as a duty solicitor, arduous though those duties are. In the fairly near future [referring to impending reform of the MHA and mental incapacity laws, and the commencement of the *Human Rights Act 1998*], the demands made on skilled solicitors in this field are going to increase exponentially.²⁸¹

Aswini Weeraratne QC told me how unusual it was for a barrister to 'take silk' (be made a QC), as she did, off the back of mental health work. However to me, the fact that there are so many practising barristers who specialise in this field in England²⁸² reflects the value placed on this work (to my knowledge, there are no barristers in Victoria who specialise in mental health law).

²⁸⁰ *Fhagen v Miller*, 29 NY 2d 348, 355 (1972) (the decision actually refers to the MHLS' predecessor, the Mental Health Information Service).

²⁸¹ *R v Legal Aid Board, ex p Duncan and Mackintosh* [2000] EWHC Admin 294, [571]–[572].

²⁸² Numerous barristers' chambers have specific mental health and Court of Protection teams, eg 39 Essex Chambers, see <<http://www.39essex.com/practice-area/administrative-and-public-barristers/mental-health-law/>> and Doughty St Chambers, see <<http://www.doughtystreet.co.uk/civil-expertise/mental-health-and-court-of-protection>>.

‘We know the law, we know the charts better than the doctors, we know our cases... [The judges] might not agree with us but they respect us in the end...’

– Sara Rollyson, MHLS, New York

On the ground, the people I spoke with felt that lawyers and their role are respected by the English MHT, and this was certainly what I observed. In each hearing, the judges asked the lawyers to advise, for instance, as to the order in which the evidence should be taken, recognising that they had discussed these matters with their clients and would be in the best position to advise how the hearing could be most fair to the patient. In one hearing I observed, the judge offered multiple opportunities to stand the matter down (at both the commencement and during the hearing) so the lawyer could properly advise and obtain instructions from her client (regarding a potential conflict of interest with an MHT member, regarding hospital observers who did not have prior permission to attend and regarding new information arising during the hearing on which the lawyer had not had a prior opportunity to take instructions). Both judges and lawyers told me that lawyers would never be cut off from speaking or making submissions. This reflects a recognition that lawyers are present and speaking at the hearing at the patient's request, and so by respecting the lawyer the MHT is respecting the patient.

Comparison with Victoria

In MHDL's experience, there is considerable variation in the attitudes of Victorian MHT members towards legal representatives. While some understand our role well, welcome our presence and respect our participation in the hearings, many seem indifferent and a minority are unreceptive and at times hostile to our presence and participation. It is notable that there is no discussion of lawyers or the role or value of legal representation in either of the MHT's guidance documents on the conduct of MHT hearings.²⁸³

How lawyers respond and act to protect their clients' rights

There is no static representative model for lawyers in mental health proceedings. Instead, the relationship is dynamic, with a constant need to assess and advocate a client's rights within the broader context of the objectives of care and welfare. Lawyers should not take the rigours or subtleties involved in performing this 'delicate duty' for granted.²⁸⁴

Thorough preparation

Preparation was routinely emphasised to me as critical for providing a good service to the client, the 'most important aspect of a case'²⁸⁵ and '90% of what wins cases'.²⁸⁶ The lawyers I spoke with in both jurisdictions investigate their clients' instructions in order to obtain independent corroborative evidence, organise witnesses and routinely consider obtaining independent experts (discussed further below). Such preparation is essential as, in both jurisdictions, the right to seek judicial oversight of mental health detention is limited in frequency; this makes each hearing critically important. The consequential importance of each hearing also means that greater consideration of strategy is required, and the timing of the hearing to maximise the chance of success is particularly critical. When asked what is the most important thing a lawyer needs to do to protect their client's rights, English service user Ian Callaghan said, 'I think they need to make appropriate recommendations about timing of [MHT hearings] and know the person well enough to know when this is the case'.

²⁸³

A Guide to Solution-Focused hearings in the Mental Health Tribunal (2014) and *A Guide to Procedural Fairness in the Mental Health Tribunal*, above n 260. The only substantive reference to legal representatives is in the Foreword of the procedural fairness guide:

For some time, the former [Mental Health Review Board, which was replaced by the MHT on 1 July 2014,] wanted to work with legal representatives to articulate a framework to guide representation in this most particular of jurisdictions. Legal representatives were keen to be part of this process, but a necessary starting point for such collaborative work is for the Tribunal to be clear about our approach in order to determine how advocates might contribute most effectively (at 6).

To our knowledge, the MHT has not yet engaged with VLA or other legal representatives on this.

²⁸⁴

Maria Bisogni, 'What is the role of a legal representative before the Mental Health Review Tribunal?' [2002] *Law Society Journal* 72, 74.

²⁸⁵

Richard Charlton.

²⁸⁶

Tam Gill.

Preparation is ‘90% of what wins cases’

– English lawyer Tam Gill

In England, while preparation for hearings in relation to section 2 patients is necessarily more limited due to the tight timeframes, most lawyers see their clients on at least four separate occasions over the course of a regular section 3 MHT case: to initial instructions, to discuss the report, immediately prior to the hearing and again subsequent to the hearing to discuss the written reasons and next steps.²⁸⁷ In between the first and second meetings, lawyers are trained to check the admissions papers to ensure the admission is lawful, review the medical records (which is ‘key to understanding the case and obtaining a fuller picture than will be in the reports’²⁸⁸), speak to the nearest relatives and nursing staff if appropriate with the client’s consent, and obtain the reports and ensure they conform with the MHT’s practice direction.²⁸⁹ Service user Ian Callaghan said that he, like most service users he knows, always uses the same lawyer, which leads to an efficiency and ease of preparation:

I usually meet face-to-face just a couple of times before the hearing with a few phone calls to check details. That seems to work well – I could ask for more meetings if necessary. My lawyer comes from London (my hospital was about 50 miles away) and she was always happy to come to see me there.

In New York, as noted above, there is limited formal documentation prepared by the hospital in relation to the hearing. However, MHLS lawyers speak to the treating team and read the clinical file in order to understand the case and how to challenge it. Preparing for the case obviously also involves speaking with their clients, something made easier by their regular presence on site at the hospitals and the fact that many clients are already well-known to the lawyer covering the particular hospital or another member of staff from previous admissions. The number of times the lawyer will meet with their client in order to prepare for a hearing varies significantly, depending on how much notice they receive before the hearing, how long the client has been in the hospital, the complexity of the case and how well-known the client already is; it might be one or two times up to dozens of times. Because the lawyers are so frequently on site, the meetings may range from quite brief interactions to lengthy, in-depth conferences.

In Washington DC, legal representation at more than a third of mental health hearings is provided by the DCPDS MHD. By limiting the number of cases they take on,²⁹⁰ Kim Clark said that the DCPDS MHD is ‘able to provide a really high-quality service, which is reflected in our results’ (meaning higher than average rates of discharge). One important aspect of case preparation at the DCPDS MHD is the role played by on-staff ‘investigators’. Kim explained how they capitalise on the permissible use of hearsay in these proceedings by gathering as much information as they can (in contrast, the rules of evidence in New York would make such evidence inadmissible). The lawyers brief the investigators and give them instructions as to who to contact to gather information to help prepare the cases. This might include visiting the scene of a particular event, looking up records and contacting friends to verify information. The DCPDS MHD has chosen to expend funding on the investigator role (it is not required by statute), which Kim considers ‘absolutely’ worthwhile: ‘knowledge is power – this really helps us win hearings’.

In New Jersey, the NJOPD MHA also employs investigators, who not only meet the civil service qualification for an investigator but also have 30 credits in psychology or social work.²⁹¹ They will make initial contact and meet with patients within a few days of the service being requested. The lawyer will then see the patient usually a day or two before the hearing. NJOPD MHA director Patrick Reilly said the supporting role of the investigators was very important as it allows the lawyers to argue ‘not just on the law but on clinical issues’. Being able to cross-examine effectively on clinical and related issues, such as knowing what treatments and services are available, makes them more effective in their advocacy.

²⁸⁷ Peter Edwards’ staff. The MHLA advocates lawyers seeing their clients this frequently: *Law Society accreditation scheme training coursebook*, above n 74, 158-159. A 2011 report found that lawyers met with their clients on average 2.56 times in relation to an MHT hearing: CQC and Administrative Justice and Tribunals Council, above n 159, 14.

²⁸⁸ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 157.

²⁸⁹ Ibid 155-159.

²⁹⁰ See the discussion of this under ‘Meeting demand for legal representation’ in Part 3A above.

²⁹¹ Patrick Reilly.

It is important to note that the US practices I saw and learned about are not reflective of the standard of legal representation across the US, which varies considerably and is often ineffective.²⁹² A case from Delaware County, Pennsylvania, which was decided on 7 May 2015 while I was in New York, demonstrated this clearly. In *TR v Havens*,²⁹³ it became evident that the practice of the court-appointed lawyer was to eavesdrop on the conversations between his appointed clients and their treating doctor from an adjoining room and, if the clients agreed to follow the doctor's recommended course of treatment, the lawyer would, without meeting with the client, waive their right to a hearing and consent to a 20-day confinement. The lawyer explained that he felt this practice was more therapeutic than troubling his clients to inform them of their rights.²⁹⁴

Getting independent expert evidence

Part of the preparation of a case may involve obtaining independent psychiatric evidence to challenge the opinion of the treating psychiatrist as to diagnosis and the need for treatment, legal compulsion and detention.

Most of the [US] courts that have considered this issue agree that the constitutional right to counsel "includes the right to an independent psychiatric examination." As a New Jersey trial court phrased it:

No matter how brilliant the lawyer may be, he is in no position to effectively contest the commitment proceedings because he has no way to rebut the testimony of the [hospital] psychiatrist.²⁹⁵

In *Goetz v Crosson*,²⁹⁶ the Second Circuit of the US Court of Appeals held that the due process clause did not require the appointment of an independent psychiatrist in every involuntary civil commitment case, but added:

Some proceedings may present a need for independent psychiatric testimony in addition to that offered by the state to ensure an accurate decision. As a practical matter such proceedings are limited to cases in which the presiding judge determines that the record leaves unexplored or unanswered questions and that additional psychiatric testimony is necessary. In such cases, the individual's interests in both freedom and self-protection are directly affected, and the failure to provide such testimony may implicate due process concerns.²⁹⁷

One area in which limited resources made a difference to the MHLS was its ability to commission its own experts to offer a countering view to the treating psychiatrist:

It would be great if we had unlimited budget and we could hire our own experts to testify at every single case, and we do have a budget for this but it's small so we have to pick and choose our cases for that, whereas it would be great if everyone had it.²⁹⁸

Accordingly, where an MHLS lawyer feels that an independent psychiatric opinion would be beneficial for their client's case, they will usually just ask the court to appoint an independent examiner, and the court will then delay the proceeding until their report is obtained.²⁹⁹

In England, it is up to the patient and/or their lawyer to organise an independent expert. While independent reports are not commonly obtained for non-forensic mental health hearings,³⁰⁰ at the compulsory training course for lawyers seeking admission to the Law Society's mental health accreditation scheme,³⁰¹ the MHLA instructed attendees to consider the instruction of an independent expert in every case. The importance of considering this in every case is reinforced by the fact that peer reviewers auditing mental health files expect a file note to explain any decision *not* to instruct an independent expert.³⁰² Lawyers are not required to obtain prior authorisation from the Legal Aid Agency before obtaining an expert report but 'clear and detailed justification for obtaining expert reports, and [expert witness] attendance at hearings' must be recorded on the file.³⁰³

²⁹² Michael Perlin.

²⁹³ 14-3987 (3rd Cir, 2015).

²⁹⁴ Ultimately, the US Court of Appeals for the Third Circuit dismissed the person's claim against Delaware County and Havens (the state-appointed lawyer who 'represented' him) on the basis that there was no evidence that Delaware County sanctioned or controlled Havens' approach and in any event the state is not required to appoint a lawyer as long as the patient is provided 'qualified and independent assistance': *TR v Havens* 14-3987 (3rd Cir, 2015). However, since the case was filed, and at the direction of Delaware County's president judge, Havens now meets with patients he is appointed to represent: Gina Passarella, 'Lawyer's Civil Rights Suit Over Involuntary Commitment Nixed', *The Legal Intelligencer* (Pennsylvania, 8 May 2015).

²⁹⁵ Perlin and Cuculo, above n 178, § 6-9, at 6-115, quoting *In re Gannon*, 123 NJ Super. 104, 105, 301 A2d 493 (Ct. Ct, 1973).

²⁹⁶ 967 F2d 29, 34 (2nd Cir, 1992).

²⁹⁷ *Ibid* [32].

²⁹⁸ Sara Rollyson.

²⁹⁹ *New York Judiciary Law* § 35.4 provides that, 'when a person is alleged to be mentally ill, mentally defective or a narcotic addict, the court which ordered the hearing may appoint no more than two psychiatrists, certified psychologists or physicians to examine and testify at the hearing upon the condition of such person' and that all costs 'shall be a state charge to be paid out of funds appropriated to the administrative office for the courts for that purpose'. The MHLS is required to 'assist in obtaining' any additional psychiatric, psychological, medical or expert opinion from a panel of 'highly qualified psychiatrists [which] shall be constituted and maintained by the presiding justice [of the Supreme Court] in cooperation with the New York Academy of Medicine in consultation with the local chapters or branches of the psychiatric or medical profession': 22 NYCRR 622.4.

³⁰⁰ Peter Edwards' staff.

³⁰¹ See 'Law Society's accreditation scheme and guidance' in Part 5B below.

³⁰² MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 158. See also 'Peer review' in Part 5B below.

³⁰³ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 131.

Reflections

Having the time to undertake adequate preparation is a challenge for MHDL lawyers. While we have a number of long-term clients who are well known to us and with whom we have more time to prepare, most compulsory inpatients receive legal representation from MHDL as part of a two-day duty lawyer service, where the lawyer will attend the hospital the day before the hearing to get instructions, go through the service's report with the client and review the clinical file, and will re-attend the next day to appear at the hearing. The time between obtaining instructions from the client and the hearing allows only a very limited window to contact potential witnesses, to seek corroborating information and to otherwise prepare.

The duty lawyer service was established in this way because, under the old *Mental Health Act 1986* (Vic), services only had to provide their reports and access to the clinical file 24 hours before the hearing. Furthermore, patients often did not receive much notice of their hearings, which limited their ability to engage with legal representation much earlier. Since the new MHA commenced in July 2014, services are required to provide their reports and file access at least 48 hours before the hearing. While this is still a very short window (and many services still routinely fail to comply with this requirement), this increase may allow MHDL to consider reshaping its duty lawyer service to enable greater preparation time, particularly if the MHT takes a more active role in enforcing the timely provision of reports.

Because MHDL provides its mental health legal services primarily on a duty lawyer model, it is very rare for us to arrange for an independent expert to assess our clients and give evidence before the MHT. Patients have long had a statutory right to seek a second psychiatric opinion at any time.³⁰⁴ However, in practice, second opinions are typically provided by psychiatrists employed within the service where the person is being detained and treated. They are thus not independent and are perceived to be of limited utility. Acknowledging this, when the new MHA was introduced in 2014, the Department of Health promised to establish a panel of psychiatrists to provide publicly-funded, independent second opinions as to whether the compulsory treatment criteria are met and whether detention is necessary for the provision of that treatment. However, the process for establishing the second psychiatric opinion service is still underway and not expected to be operational until April 2016.

Insistence on due process and fair hearing requirements

In various ways, the lawyers I met were very insistent on due process and fair hearing requirements when preparing for and providing representation during mental health hearings. However, the forms which this took depended on the nature of the jurisdiction and local laws.

For instance, in New York, commitment to due process was reflected in the fact that the MHLS represents everyone (even those not attending their hearings or unable to provide clear instructions) to ensure that the adversarial process is balanced and that the State is challenged to prove its case.

The insistence by MHLS lawyers on the strict application of procedure and the rules of evidence also reflects a concern for due process. The hearings I observed were full of motions and objections from lawyers on both sides, sometimes quite heated, many of which related to the application of the rules of evidence and in particular the exclusion of hearsay evidence and historical information lacking in relevance. As a result, information about prior hospitalisations and even the reasons for the current admission (unless recent) may be excluded. These rules also prevented the doctor from giving evidence about things they had not directly observed unless they were expressly included in the clinical file. For instance, in one hearing I observed, the doctor was not permitted to elaborate on how the patient had 'touched' someone because the staff member who witnessed it had not specified it any further in his file entry (even though the doctor had had a conversation with that staff member about what 'touched' meant and had asked the staff member to update his file entry to be more specific).

³⁰⁴ *Mental Health Act 1986* (Vic) s 18(1)(a);
Mental Health Act 2014 (Vic) s 79(1).

‘I would have thought that most people would prefer to have their lawyer fight their corner as much as possible than take a more “softly softly” approach.’

– English service user Ian Callaghan

In England, lawyers’ insistence on fair hearing requirements was more evident in their efforts to chase the timely provision of reports prior to the hearing and their willingness to seek adjournments where there was insufficient time to prepare (for instance, if the reports had been received late) or where one or more of the report authors (or stand-ins with adequate knowledge of the person) are unavailable to attend the hearing to be cross-examined. It was also evident in the way in which lawyers facilitate and maximise their clients’ participation during the hearings by requesting the evidence be taken in the order preferred by the client and by carefully and supportively leading them through their evidence.

Reflections

The lawyers’ ability to insist on due process and fair hearing requirements is significantly aided by the evident respect which the judicial decision-makers in both jurisdictions already have for these principles. This meant, for instance, that MHLS lawyers generally did not need to explain the basis for their objection to the admissibility of evidence and the MHT readily accepted the necessity of report authors being present and demanded this themselves. Furthermore, at least in the hearings I saw, the MHT welcomed patient views as to the appropriate order for proceedings and readily offered the opportunity for the person to have a break or an opportunity to conference with their lawyer during the hearing. The fact that the MHT hearings were not at all rushed also strengthened the impression that the hearings were conducted fairly.

Finally, the respect accorded by the judicial decision-makers in both jurisdictions to the lawyer and the lawyer’s role also reflects their appreciation of fair hearing principles: as the lawyer is the person’s representative and the means through which they have chosen to present their case, to cut off the lawyer from making submissions or to otherwise disrespect them in effect cuts the person off from participating in the hearing and amounts to disrespect of the person themselves.

Robust advocacy and scrutiny of evidence

All lawyers I spoke with saw robust advocacy as vital in mental health hearings because liberty and other important rights are at stake. This means that the clinical evidence must be carefully scrutinised through cross-examination and strong legal submissions made to advance the client’s instructions. Katherine McCabe noted that, as the person’s lawyer, you will often know a lot more about them and their circumstances than the other people in the hearing, especially if they are in a busy ward, and so being prepared to undertake detailed cross-examination is important to ensure the accuracy of information being put before the decision-maker.

Dr Lucy Series noted that lawyers have a duty to push any point to help achieve their client’s wishes and suggested that it is ‘disrespectful to the law’ for either lawyers or judges to not engage with legal arguments.

Peter Edwards described the importance of lawyers standing up to the MHT because, as officers of the court and parties to the case, lawyers have a duty to assist the MHT to fulfil its mandate in the MHA (which includes to act fairly) and to prevent it from falling into error. For instance, if a client interrupts a clinician’s evidence during a hearing to state their view, the MHT is likely to say, ‘Wait until it’s your turn’. However, if the client will not be able to make their point later (for instance, because they will forget or become too agitated), being forced to wait means that they would be prevented from effectively participating in their own hearing. Peter Edwards has trained his lawyers to intervene in these circumstances to remind the MHT of its fair hearing obligations and the need for flexibility and reasonable accommodations.

‘Without the presence of [active, trained] lawyers, it is inevitable that patients will *not* effectively participate, will not be treated with dignity, and will *not* perceive such hearings as being “fair”.’

– Emeritus Professor Michael Perlin, New York

From a service user/survivor perspective, Tina Minkowitz demanded a strong, adversarial stance by MHLS lawyers in hearings.³⁰⁵ Similarly, Ian Callaghan said that ‘a good lawyer is someone who... is very assertive’. He said that his lawyer ‘was very firm during Tribunals [ie hearings] and argued [his] case well’. When asked whether he thought lawyers should ‘tone down’ their advocacy or not push the case too hard in case it might agitate or stress their client, Ian disagreed:

I think people would much prefer to have their lawyer be as challenging as possible [to the doctors and MHT], I know I certainly would...

Tribunals are very stressful anyway, so lots of ‘arguing’ may indeed increase this distress, but I would have thought that most people would prefer to have their lawyer fight their corner as much as possible than take a more ‘softly softly’ approach. I hear people saying how forceful their lawyer was in this way and that that was a good thing, more than people saying they would have preferred that this had not been the case. Most people are so desperate to get the outcome they want (discharge or move to lesser security) that I think they’d be prepared [for] – and expect – their lawyer to do whatever it takes. Of course, there are bound to be exceptions, but I really do think they would be much less frequent. I think it’s more likely people would be disappointed and frustrated if their lawyer hadn’t tried as hard as possible to help them achieve what they were after.

Ian emphasised the importance of the trust relationship between the patient and their lawyer: ‘if the lawyer and the person having the hearing have properly briefed each other on expectations and likely questioning, I wouldn’t have thought there would be too much of a problem’.

‘Therapeutic’ considerations in advocacy

Therapeutic jurisprudence (‘TJ’) is an interdisciplinary field of study which examines ‘the role of the law as a therapeutic agent’³⁰⁶ – the impact of the law and the legal process on participants’ mental health and wellbeing. It aims to promote laws and legal processes that promote therapeutic outcomes and minimise counter-therapeutic ones.

It first emerged in the US in the late 1980s and early 1990s and has been very influential in certain jurisdictions, including in the establishment of specialist ‘problem-solving’ courts in Victoria like the Drug Court, Koori Court and ARC List. The Victorian MHT identifies TJ as a key concept underpinning its ‘solution-focused’ approach.³⁰⁷

However, TJ is not without its critics. Back in 1995, Christopher Slobogin highlighted five dilemmas with TJ.³⁰⁸ More recently, Professor Peter Bartlett (who is professor of mental health law at the University of Nottingham) said to me:

My own view (for which I do not claim to be typical of anyone, either here [in England] or anywhere else!) is that [TJ] is in the end unsatisfactory. If the point is that you should treat people like human beings, and think about how we run things on that basis, I am not sure you need a grand theory for that. If it means that we should reimagine court processes as therapeutic processes, then I have real problems with that: they are court processes, and in the end that is unavoidable (even if one wished to avoid it, which I am not sure that we do). I also think there are unstated assumptions in TJ that need to be challenged. It is all well and good to say that we should be aware that some effects of legal process may be therapeutic or anti-therapeutic, but in the end people need to be able to access law, whether it’s good for them or not, and so much of the TJ results (mental health courts, for example) are in the end coercive, but because in theory ‘voluntary’, uncontrolled. From a legal perspective, that is a real problem that I don’t think TJ has really sorted out.

³⁰⁵ Mental Hygiene Law Court Monitoring Project, above n 272.

³⁰⁶ David B Wexler and Bruce J Winick (eds), *Essays in Therapeutic Jurisprudence* (Carolina Academic Press, 1991) 8.

³⁰⁷ MHT (Victoria), *A Guide to Solution-Focused hearings in the Mental Health Tribunal*, above n 283, 13-15.

³⁰⁸ The dilemmas are: Is TJ distinguishable from other jurisprudences that share its goal of using the law to improve the well-being of others? Can the term ‘therapeutic’ be defined in a meaningful way? Will the vagaries of empirical research, on which TJ heavily relies, doom its proposals? How will a TJ proposal that benefits only a subgroup of those it affects be implemented? When and how should a TJ proposal be balanced against countervailing constitutional and social policies? See Christopher Slobogin, ‘Therapeutic Jurisprudence: Five Dilemmas to Ponder’ (1995) 1(1) *Psychology, Public Policy, and Law* 193.

Citing TJ principles, lawyers are sometimes criticised on the basis that their advocacy style – or even mere presence – in mental health hearings may distress their client and/or undermine the therapeutic relationship between patient and clinician which would be counter-therapeutic and not in their client's best interests.³⁰⁹ Mental health hearings are indeed a challenging context in which to provide legal representation:

[MHTs] are required to apply legal criteria within a clinical context that may cause tension between law and psychiatry. The work of tribunals brings into focus the contradictory forces of medical paternalism and personal liberty.³¹⁰

However, rather than suggesting that lawyers should approach advocacy softly and gloss over potential conflicts between the positions of their client and the treating team so as not to agitate their client, Emeritus Professor Michael Perlin (who has been working in this field for decades and has contributed heavily to the development of TJ) strongly believes that TJ 'demands' robust, rights-based advocacy in all mental health hearings:

TJ demands the presence of active, trained lawyers at all such hearings. Without the presence of such lawyers, it is inevitable that patients will *not* effectively participate, will not be treated with dignity, and will *not* perceive such hearings as being "fair". TJ demands that lawyers at such hearings be active, and focused on the enforcement of their clients' legal rights (citation removed, emphasis in original).

None of the English lawyers I asked had heard of TJ, despite their descriptions and the practices of advocacy I observed generally being consistent with TJ principles. For instance, Tam Gill described not being unduly adversarial, being conscious of the ongoing care relationship between patient and clinician and not unduly raising the client's expectations. Even in matters where there is no real chance of discharge, she still puts her client's case forward but advocates less stridently than in stronger cases. Reflecting a care for the impact on her clients, she said that she reminds the MHT in every matter that the patient will sit in their room reading and re-reading the written reasons (which the MHT must provide in every matter) and so, regardless of the decision, it would be helpful for them to draw attention to any positives. However, she baulked at the suggestion that advocacy should ever be toned down for 'therapeutic' reasons where there was a legitimate issue to pursue. Dr Shah shared this view: 'When the issue at stake is one of liberty... therapeutic considerations must not be the overriding consideration'.³¹¹

As Michael Perlin explains, TJ, properly understood, does not preference wellbeing over procedural fairness and other essential rights protections:³¹²

[The] ultimate aim of [TJ] is to determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential *while not subordinating due process principles*. There is an inherent tension in this inquiry, but David Wexler – one of the two creators of TJ – clearly identifies how it must be resolved: The law's use of "mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns."³¹³ Again, it is vital to keep in mind that "[a]n inquiry into therapeutic outcomes does not mean that therapeutic concerns 'trump' civil rights and civil liberties"³¹⁴ (citations in original, emphasis added).

TJ scholars have also noted that lack of due process and rigour 'can have severe anti-therapeutic consequences for the patient, who will lose trust and confidence in the judges, lawyers, and clinicians involved and in the genuineness of their purportedly benevolent intentions... [which may also have] potentially negative consequences for the efficacy of the commitment process'.³¹⁵

Appeals and other legal challenges

Legally challenging a decision thought to be unfair or unlawful protects the person's rights by providing the opportunity for the correct process to be followed and for a lawful decision to be reached. As explained under 'Perceptions of the English MHT' below, the volume of legal challenges conducted against MHT decisions was also identified as a major factor contributing to the improved quality of the MHT because legal challenges hold decision-makers to account and facilitate consistent, lawful practices (see also 'Judicial review and other direct legal challenges' in Part 3C below). However, seeking a 'rehearing and review' of the Supreme Court judge's initial decision was not identified as such an influential feature in New York.

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Eg Debra Rigby, 'Tasmanian Mental Health Representation Project – A practical example of therapeutic jurisprudence' (presentation at 3rd International Conference on Therapeutic Jurisprudence, Perth, June 2006); Bisogni, 'What is the role of a legal representative before the Mental Health Review Tribunal?', above n 284 74; Janet Abisch, 'Mediation Lawyering in the Civil Commitment Context: A Therapeutic Jurisprudence Solution to the Counsel Role Dilemma' (1995) 1 *Psychology, Public Policy and Law* 120, 127.

310

Shah, above n 118, 30.

311

Ibid.

312

Similarly, TJ co-creator Bruce Winick has stated, 'Unlike the medical model [TJ] does not privilege therapeutic values over others. Rather, it seeks to ascertain whether law's anti-therapeutic effects can be reduced and its therapeutic effects enhanced without subordinating due process and other justice values': 'A therapeutic jurisprudence model for civil commitment' in Kate Diesfeld and Ian Freckleton (eds), *Involuntary Detention and Therapeutic Jurisprudence: International Perspectives on Civil Commitment* (Ashgate, 2003), 26.

313

David B Wexler, 'Therapeutic Jurisprudence and Changing Concepts of Legal Scholarship' (1993) 11 *Behavioural Sciences and the Law* 17, 21.

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Michael L Perlin, 'A Law of Healing' (2000) 68 *University of Cincinnati Law Review* 407, 412; Michael L Perlin, "'Where the Winds Hit Heavy on the Borderline': Mental Disability Law, Theory and Practice, "Us" and "Them"' (1998) 31 *Loyola of Los Angeles Law Review* 775, 782.

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Bruce J Winick, *Civil Commitment*, above n 248, 145.

Nevertheless, it is important to note that in neither jurisdiction were these legal challenges considered by lawyers (or the UK Legal Aid Agency funding the case) to be ‘strategic litigation’, they are simply the correct follow-up legal action to take on behalf of an individual whose rights are not being respected or who is subject to a decision that is not legally correct. Undertaking such legal challenges (where there is merit to do so) was seen as an essential part of the legal service provided to individuals; an incorrect decision cannot be left hanging. The lawyers I spoke with were concerned at the idea that a legal service might only provide representation in first-instance hearings and not follow through with appeals in respect of decisions thought to be seriously unfair or incorrect.

Prior to 2007, the only way to challenge a decision of the MHT in England was to seek judicial review in the High Court. There has been a strong tradition of judicial review in England since the 1940s.³¹⁶ Even so, mental health and disability law matters were not commonly litigated until twenty years ago. It started with a few interested lawyers like Lucy Scott-Moncrieff, Richard Charlton and Peter Edwards and gradually took off.³¹⁷ Judicial review was very common in the 1990s and 2000s, especially after the commencement of the *Human Rights Act 1998* (UK) in 2000, to test the boundaries.³¹⁸ Drawing on its strong common law traditions, the High Court was very good in these cases when it came to procedural fairness issues but more hesitant around delving into certain substantive issues such as risk.³¹⁹

The introduction of the Upper Tribunal appeals process in 2007 significantly cut down the number of judicial review cases in this field. Under this process, a party can apply to the (first-tier) MHT for permission to appeal to the Upper Tribunal on an error of law.³²⁰ A similar number of applications as had previously proceeded by way of judicial review are now made this way,³²¹ although the number is dropping:³²² as the MHT is now so procedurally fair, comparatively few of its decisions are open to challenge on the basis of a legal error.³²³ The most common reason for an application is that the MHT’s reasons for its decision were inadequate.³²⁴

Where an application for permission to appeal to the Upper Tribunal is made, the MHT will review it to consider whether there has been an error of law.³²⁵ If there is a clear or, conversely, an unarguable error of law, the MHT will deal with the application itself – often without even asking for submissions from either side³²⁶ – and in doing so has the power to correct accidental errors, amend reasons given for a decision or set aside the decision (in which case it will be remitted to the MHT to be decided again).³²⁷ If however the alleged error is less clear-cut, it will grant permission to appeal so that the Upper Tribunal can make the determination. If the MHT does not grant permission to appeal, the person can apply for permission directly to the Upper Tribunal.³²⁸ The Upper Tribunal hears about 25-30 mental health cases from England and Wales each year.³²⁹

Aside from this appeals process, the Upper Tribunal also has jurisdiction to hear applications for judicial review.³³⁰ This is useful as some decisions of the MHT are not amenable to appeal but may be amenable to judicial review.³³¹

Professor Geneva Richardson said that there was a fear that the strong common law traditions of the High Court would be lost on the Upper Tribunal when it took on responsibility for scrutinising the lawfulness of MHT decisions, but she believes these fears have not been realised. However, one limitation to obtaining helpful (precedential/educative) judgments is that so many cases are now simply remitted on the papers to be decided again.³³²

In New York, the Second Department MHLS has a separate Special Litigation and Appeals Unit, and most of the unit’s work relates to appeals.³³³ They conducted 39 rehearing and reviews in 2014 (two of which proceeded before a jury).³³⁴ The principal attorney-in-charge of that unit, Lisa Volpe, explained that, unless the case is frivolous, the MHLS will always help a client to challenge a decision if they want to, regardless of whether there is any strategic value in it, because it is part of their mandate to do so.

³¹⁶ Richard Charlton.

³¹⁷ Sophy Miles.

³¹⁸ Tam Gill, Geneva Richardson.

³¹⁹ Geneva Richardson.

³²⁰ *Tribunal Procedure (First-tier Tribunal) Rules 2008* (UK) r 46.

³²¹ Richard Charlton, Peter Edwards.

³²² Approximately 75 applications for permission to appeal were made in 2012: Johnson, Miles and Royston, above n 94, 280. However, Edward Jacobs, Upper Tribunal Judge and lead judge for mental health, thought that at one stage around 180 applications were being made each year: email correspondence 10 December 2015.

³²³ Peter Edwards’ staff.

³²⁴ Johnson, Miles and Royston, above n 94, 280.

³²⁵ *Tribunal Procedure (First-tier Tribunal) Rules 2008* (UK) rr 47, 49. Note that only the English MHT has the power to review its own decisions for error of law; the Welsh MHT does not have that power.

³²⁶ Johnson, Miles and Royston, above n 94, 282.

³²⁷ *Tribunals, Courts and Enforcement Act 2007* (UK) s 9(4).

³²⁸ *Tribunal Procedure (Upper Tribunal) Rules 2008* (UK) r 21(b).

³²⁹ Edward Jacobs, Upper Tribunal Judge and lead judge for mental health, email correspondence 10 December 2015.

³³⁰ *Tribunals, Courts and Enforcement Act 2007* (UK) ss 15–19.

³³¹ Johnson, Miles and Royston, above n 94, 289.

³³² Peter Edwards.

³³³ Lisa Volpe.

³³⁴ Michael Neville.

Separate to rehearing and reviews, the MHLS can also file proceedings against the Supreme Court in the Appellate Division under Article 78 of the New York Civil Practice Laws and Rules. Article 78 provides for remedies that would otherwise have been obtainable through judicial review and common law writs.³³⁵ These proceedings may be taken against a court, tribunal or other body or officer to determine whether:

- There has been a failure to perform a legal duty;
- The decision-maker has acted outside their jurisdiction;
- 'A determination was made in violation of lawful procedure, was affected by an error of law or was arbitrary and capricious or an abuse of discretion'; or
- A determination made following a hearing at which evidence was taken 'is, on the entire record, supported by substantial evidence'.³³⁶

Typically, when an Article 78 proceeding is filed, it is accompanied by a motion for a stay of the decision pending the outcome of the proceedings. If the stay is granted, the judge will often back away from the purported improper actions and the MHLS is then able to discontinue the Article 78 proceeding, essentially 'settling' the case.³³⁷ However, not least because they have to continue appearing before the same judge for a long stretch of time, the MHLS thinks carefully about whether a less confrontational approach may be more appropriate before filing any Article 78 proceedings:

[T]here are times when judges act really outside the pale and, while we could move for judicial relief... sometimes we want to avoid doing that... You don't really want to be challenging judges all the time at the Appellate Division because you're saying the judge is doing it wrong, and then have to appear before them the next day, so sometimes it's more judicious to try to do things behind the scenes and get a more reasonable response.³³⁸

Reflections

While the English MHT's approach has been tightly shaped by regular legal oversight of its decisions and processes, there has been a dearth of such legal challenges in Victoria. To my knowledge, there have only been three higher court decisions regarding the jurisdiction and operation of the Mental Health Review Board (the MHT's predecessor) since its inception in 1986³³⁹ – none of which involved a direct challenge to a Board decision – and none in relation to the current MHT.

In Victoria, there is no statutory mechanism for reviewing the lawfulness of an MHT decision. While a party can apply as of right to another tribunal – VCAT – for 'review' of an MHT decision,³⁴⁰ the review is conducted as a fresh hearing and VCAT has no authority to examine the lawfulness of the MHT's decision.³⁴¹ A party may then seek leave to appeal a VCAT decision on a question of law to the Supreme Court.³⁴² However, VCAT conducts few MHT reviews – of 24 applications made in 2014-2015, only seven proceeded to hearing and determination³⁴³ – because it is usually quicker for the person to seek a fresh hearing at the MHT. In any event, their circumstances have often changed by the time of the VCAT hearing, rendered pursuit of the hearing futile. These factors significantly reduce the chances of a matter ever progressing to the Supreme Court.

Separately, with the consent of the President of the MHT, the MHT may refer a question of law arising during a hearing to the Supreme Court.³⁴⁴ However, despite a number of important questions of law remaining unsettled under the new MHA, the MHT has not referred any questions for clarification. This leaves those unsettled questions open to recurrent argument in individual MHT hearings. There is also limited clarity about the circumstances in which the President would consent to making such a referral.

Establishing proper processes and resolving the outstanding questions of law under the new MHA through definitive, higher court decisions would reduce the need for complex legal submissions during hearings before the MHT, which are time-consuming and frustrating for all parties who would rather focus on the particular case at hand.

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'Relief previously obtained by writs of certiorari to review, mandamus or prohibition shall be obtained in a proceeding under this article': New York Civil Practice Laws and Rules § 7801.

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New York Civil Practice Laws and Rules § 7803.

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Lisa Volpe.

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Ibid.

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In the matter of XY (1992) 2 MHRBD 501 (a special case stated by the Board for the opinion of the Supreme Court); *Wilson v Mental Health Review Board* [2000] VSC 404 (an appeal to the Supreme Court on a question of law from a decision of VCAT); *MH6 v Mental Health Review Board* [2009] VSCA 184 (an appeal against a dismissal by the Supreme Court of an appeal on a question of law from a decision of VCAT). A further significant decision regarding the operation of the Board, from VCAT rather than a higher court, is *Kracke v Mental Health Review Board & Ors* (General) [2009] VCAT 646.

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Mental Health Act 2014 (Vic) s 201(1).

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The VCAT hearing is conducted 'de novo', which means VCAT stands in the shoes of the original decision-maker (the MHT) and exercises the same powers as the MHT to make the decision afresh, rather than scrutinising or reviewing the MHT's original decision, see *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 51.

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Victorian Civil and Administrative Tribunal Act 1998 (Vic) s 148. If the VCAT decision was made by the President or a Vice-President, such an appeal lies to the Court of Appeal: s 148(1)(a).

343

MHT (Victoria), *2014/2015 annual report*, above n 15, 23.

344

Mental Health Act 2014 (Vic) s 197. VCAT may also refer a question of law to the Supreme Court: *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 96(1).

Dialogue with the court

Separate and apart from conducting individual proceedings, the MHLS meets with the judiciary on occasion to discuss common practice issues, particularly if a judge is doing something which the MHLS feels would ‘really be a disadvantage to our clients and statutorily seems way outside of the norm’.³⁴⁵ Raising issues in this way may obviate the need for Article 78 proceedings. The MHLS also provides education to the judiciary when asked by the courts to do so. The MHLS engages in these interactions with the court in an effort to ensure that due process rights and statutory requirements are upheld.

In contrast, individual lawyers or law firms in England do not have any standing to approach the MHT in this way. However, the MHLA provides an opportunity for individual lawyers to share information about MHT practices across the country and the MHLA meets regularly with the MHT to raise systemic issues³⁴⁶ (see ‘Mental Health Lawyers Association’ in Part 5B below).

Reflections

Like the MHLS, MHDL prefers to attempt to resolve issues directly with MHT (particularly given the difficulties in obtaining judicial resolution of issues, described above). As the primary provider of mental health legal services in Victoria, MHDL has participated in quarterly meetings with senior members from the MHT since the MHT’s inception in July 2014 to discuss practice issues arising and to both provide and receive feedback. With the re-establishment of the MHLC’s scheme for the provision of pro-bono legal representation,³⁴⁷ the MHT has also established a Legal Users Group that includes both VLA and the MHLC.³⁴⁸ In addition, MHDL raises issues of concern to the MHT in writing from time to time. MHDL has experienced varying degrees of success from this dialogue.

Overall perceptions of judicial decision-makers and the conduct of mental health hearings

In light of the efforts of lawyers described above, I was interested to learn what impact they had on judicial decision-makers, and the degree to which judicial decision-makers and mental health hearings in each jurisdiction were seen to be respectful and protective of human rights.

To understand this, I have drawn on discussions with a range of hearing participants in each jurisdiction as well as my own observations of the hearings, rather than raw discharge rates. While rates of discharge from detention at mental health hearings do indicate something, without more they do not reveal much about the extent to which judicial decision-makers are respectful of rights. No only do discharge rates reveal nothing about the processes and interactions between the decision-makers and hearing participants, there is no way to know whether a low discharge rate means the decision-makers are conservative and not open to persuasion or whether it instead means that mental health services are rights-respecting and rarely present someone at a hearing who does not meet the statutory criteria (which obviously would reduce the need for the decision-maker to discharge them). Furthermore, in terms of exploring the ability of lawyers to influence judicial decision-makers, no comparison can be made between rates of discharge when a lawyer is or is not present because both New York and England have universal legal representation. Accordingly, discharge rates are not a particularly helpful measure.

Perceptions of New York Supreme Court mental health hearings

Mental health hearings in the New York Supreme Court are much more formal and overtly legalistic than hearings in either England or Victoria. This formality and legalism is ostensibly very rights-protecting in some ways, particularly in relation to matters of process:

- Hearings are conducted by a trained judicial officer;
- The court does not receive any information of substance prior to the hearing, which means they have not already absorbed the doctor’s narrative about the case;
- Witnesses are sworn in, which, particularly as hearings are recorded, one would expect would lead to them giving more careful and considered evidence;³⁴⁹
- Rules of evidence apply, which increases the reliability of evidence before the court; and
- The process is adversarial, with both sides legally represented and a clear onus on the detaining service to put forward evidence to establish that the criteria are met and justify the rights restrictions.

³⁴⁵ Lisa Volpe.

³⁴⁶ Tam Gill.

³⁴⁷ The MHLC provided or facilitated 40 instances of legal representation in 2014-2015: MHT (Victoria), 2014/2015 annual report, above n 15, 26.

³⁴⁸ Ibid 30.

³⁴⁹ Tina Minkowitz has criticised the court’s practice of not permitting patients to give their evidence from the witness box and thus not be treated as an equivalent witness to the psychiatrist: above n 272.

Having the Attorney-General's office appear (on behalf of state hospitals) in a formal, adversarial setting certainly changes the dynamic of the hearing. On the one hand, it is an honest reflection of the fact that compulsory mental health treatment is an exercise of state power: the person is being detained for a public purpose. Rather than relying on clinicians to present the case, legal representatives are also likely to have a better understanding of the criteria, rules of evidence and strengths of the case, and perhaps more objectivity and less emotional involvement than treating clinicians.

However, the form of the hearings is so legalistic that, coupled with their pace, they are likely to be quite inaccessible to many of the patients involved. Furthermore, while the adversarial nature of the process may facilitate negotiations, agreements and compromises because doctors want to avoid being cross-examined, it can also foster a competitive sense of wanting to win – on both sides – which may skew the presentation of evidence.

Similarly, limiting the admissibility of evidence could work either for or against a patient. In the absence of any information adduced by the hospital about their past, would the court simply assume the worst? Or does this silence allow the person to give their own evidence as to what occurred with no contradiction?

If all the formal process does is make sure a doctor has said on record, 'This criterion is met, this criterion is met...' so the judge can say, 'I have heard cogent evidence that the criteria are met', that does not seem particularly helpful, especially if the patient does not have an independent expert to provide similarly authoritative evidence. Principal attorney Sara Rollyson assured me that there had been judges who would say, 'Well, I have heard the evidence but it wasn't credible', but whether such scrutiny is applied to the evidence really depends on the judge.

Accordingly, perceptions of the New York Supreme Court's conduct of mental health hearings were heavily linked to which particular judge was conducting the hearings. Like lawyers in New Jersey and Washington DC, MHLS lawyers reported significant variability between assigned judges: they may either be pro-rights and require lots of convincing by the State to limit a person's rights, or somewhat fearful, protectionist and more concerned to just make sure the person gets treatment.

Sara Rollyson explained that the judge I observed in the Supreme Court in Brooklyn was quite new to the role. Apparently, assigned judges receive no training to prepare them:

[When she started,] she needed a definition of what schizophrenia is, what is bipolar... So they need to know everything, they have no idea.³⁵⁰

While the Brooklyn judge was very respectful, she was not very assertive in conducting the hearings. For instance, Sara said that other judges would have been quite appalled and would have 'called out' the Attorney-General's representative for admitting documents into evidence despite admitting she had not even read them in one hearing I observed. Similarly, when a witness in another matter gave very equivocal evidence, Sara said that other judges would have been more assertive and said, 'Either you know or you don't know because someone's liberty is at stake'. Sara also noted that this judge still tends to make orders for the maximum duration in the knowledge that the doctors can discharge the patient sooner:

Other judges will narrowly tailor [the orders]. I'm hoping... maybe after she starts to see what goes on in the hospitals a little bit more... I mean the building itself is new and all shiny [but] our problems are more, why is the social worker taking three months to get [outpatient treatment organised] for someone who is ready for discharge now? Should that person be in the hospital for an extra three months because they are on vacation?

As noted above, judges in New York (like New Jersey and Washington DC) are appointed for long stretches to deal with mental health cases. Lawyers reported frustration at getting 'stuck' with a judge who was not interested in or did not 'get' mental health work. Tina Minkowitz strongly recommended a 'rotation of judges in the Mental Hygiene Part [of the Supreme Court] to provide a better chance of a fair hearing'.³⁵¹

³⁵⁰
Sara Rollyson.

³⁵¹
Above n 272.

The New York hearing processes were so different from anything I had seen before, and I really wondered what services users at the centre of these processes thought of them. There does not seem to be much written on the subject since Tina Minkowitz's scathing report in 1997, in which she noted that '[o]ften [the person's] testimony is quite eloquent, yet it is typically met with disinterest or worse from the court'.³⁵² Noting that perspectives vary and that it is 18 years since that report, I put out a request through a New York service user/survivor network to discuss these issues further. However, I did not have the opportunity to speak with anyone else in New York about this (and only spoke with other US service users in Washington DC).

Perceptions of English MHT hearings

On the whole, perceptions of the English MHT were much more favourable than perceptions of the New York Supreme Court.

In 2002, Justice Stanley Burnton of the English High Court noted the importance of the MHT's work and function:

The issues before Mental Health Review Tribunals are probably the most important issues decided by any tribunals. The Tribunals make decisions as to the compulsory detention and treatment, and thus the liberty, of the individual... The decisions of the Mental Health Review Tribunals are as intrinsically important as many of those of the Crown Court.³⁵³

Reflecting the recognised importance of its work, my overall impression was that the MHT performed its role earnestly and well, notwithstanding that it lacked the formality and legalism of the New York Supreme Court. The lawyers I was with described the hearings I observed as typical and representative of how hearings are usually conducted.

In fact, the lawyers I spoke with all positively rated the MHT. Tam Gill felt that, on the whole, the MHT was now very good at performing its role properly, in applying the law correctly, in engaging well with clients and in actively listening to submissions. Peter Edwards and John O'Donnell also felt that the MHT works well and Richard Charlton noted it was largely consistent in its decision-making.

Speaking as a service user, Ian Callaghan described more variability in the MHT's practice:

I think Tribunals vary hugely and people report very different experiences. I think everyone finds them stressful and has mixed feelings about them. Most people are hoping for a particular outcome and while I don't know precise figures, I think the majority of people are probably disappointed with the outcome.

He nevertheless felt that 'on the whole [the MHT] approach[es] cases with an open mind' rather than simply as a 'rubber stamp' for whatever the treating team wants.

From a clinician's perspective, Dr Samrat Sengupta described the MHT as 'very adversarial'. However, he used this term in a positive light, drawing a link between a robust hearing and rights being very well addressed and protected by the MHT. He described the hearings as very thorough, with evidence well considered. He said that most psychiatrists – including those who trained him and those he works with – see an adversarial process as better at protecting rights and appropriate given the rights issues at stake for the patient. He felt that clinicians' respect and appreciation for such thorough hearings was simply part of the English clinical training and experience. When considering whether an adversarial approach could go too far, he gave an example of a ten-day hearing, where both sides had called independent witnesses and he was cross-examined for two full days, and agreed a balance must be struck between ten-day hearings at one extreme and the risk of unjustified detention on the other.

Many noted that it had not always been this way, and that the MHT used to be far less rigorous and rights-focused. In 2006, a survey of MHT members, MHA administrators and legal representatives found that the overall stakeholder satisfaction rating had dropped to 18% (compared to 87% for other government departments and agencies)³⁵⁴ and, in 2007, the Tribunal Service's Acting Chief Executive made the frank admission that it was the 'worst performing tribunal, whose performance needed to be turned around quickly'.³⁵⁵ Concerns principally related to poor quality administration and delays which were negatively impacting on patients' rights to a fair and speedy hearing.³⁵⁶ In addition, 'a significant minority of respondents did not feel they were given sufficient opportunity to be heard[, a] third did not feel listened to [...] some claimed that the panel members seemed uninterested [and n]early half felt that the tribunal did not give equal importance to their views as compared with other witnesses'.³⁵⁷

³⁵² Ibid.

³⁵³ *R (KB) v MHT* [2002] EWHC 639 (Admin), [32].

³⁵⁴ CQC and Administrative Justice and Tribunals Council, above n 159, 4.

³⁵⁵ CQC and Administrative Justice and Tribunals Council, *Patients' experiences of the First-Tier Tribunal (Mental Health): Report of a joint pilot project of the Administrative Justice and Tribunals Council and the Care Quality Commission* (undated, unpublished copy provided to me by an interviewee) 1. In the formal version of this report (above n 159), this comment was replaced with the more general: 'It was acknowledged that the MHT was, at that time, the poorest performing tribunal and urgent and specific action was needed to remedy the problems and achieve real and lasting improvements in the tribunal's administration': 9.

³⁵⁶ CQC and Administrative Justice and Tribunals Council, above n 159, 4.

³⁵⁷ Ibid 6.

‘there’s no doubt there have been huge improvements since it moved to the Ministry of Justice..’

– English lawyer Richard Charlton, on the MHT’s move from the Department of Health to the Ministry of Justice

The improvement in the MHT’s functioning over the last decade was commonly attributed by people I spoke with to two factors: the volume of legal challenges to its decisions (discussed under ‘Appeals and other legal challenges’ above), and its move out of the Department of Health into the Ministry for Justice.³⁵⁸

In 2007, the MHT moved from sitting within the Department of Health to sitting alongside other tribunals as part of the ‘First-tier Tribunal (Health, Education and Social Care Chamber)’ within the Ministry of Justice. This was something which the MHLA had pushed for.³⁵⁹ Previously, it was:

- A judicial body sitting outside the regulation of other judicial bodies;
- In a conflicted position because the Department of Health runs and funds the NHS and was responsible for the detention of patients appearing before it; and
- A low priority generally for the Department of Health.³⁶⁰

In Richard Charlton’s view, ‘there’s no doubt there have been huge improvements since it moved to the Ministry of Justice... it has made an enormous difference’:

- Hearings now take place in the timeframes they are meant to;
- There is a much better system for enforcing the provision of reports from services; and
- The quality of decision-making is better and more consistent as a result of training and resources. MHT members have also been exposed to the more ‘judicial’ approaches to conducting hearings and making decisions of the other tribunals they now sit alongside.

Two experienced MHT judges both said that they had experienced an increase in professionalism and quality of the MHT over this time. They noted that the MHT still retains a unique approach but is much more internally consistent, with a better quality of decision-making and more organised listings and directions. Richard Charlton said that some people may feel the MHT now places too much emphasis on efficiency over justice; ‘they’re probably right but the dark days of the MHT are over’.

Conclusion

I was left with the feeling that, while the New York mental health hearings put on an energetic show of rights protection, it made little difference to the overall legal outcomes and meaningful protection of rights when compared with the subtler and more in-depth approaches of specialist tribunals like the MHT. Katherine McCabe, an English mental health lawyer who has been volunteering with the MHLS in New York for the last year, shared these views.

The English MHT seemed to approach its cases very deliberately, with careful preparation, with a broader range of evidence before it and with adequate time during the hearing to ensure all issues were explored. No doubt the knowledge that the patient cannot simply put in a fresh application to the MHT immediately after the hearing – and may in fact be prevented from having another formal hearing for quite some time – contributes to this earnest approach. Without an immediate right to a fresh hearing, it is much less acceptable for the MHT to simply dismiss a borderline case saying, ‘It’s just a bit too soon’.

³⁵⁸ Richard Charlton, Peter Edwards, Geneva Richardson, Aswini Weeraratne QC, (anonymous).

³⁵⁹ Richard Charlton.

³⁶⁰ Ibid; Shah, above n 118, 27.

... it seems that the more a mental health court or tribunal is inquisitorial and takes a critical, questioning approach to the service's evidence, the less legalistic and adversarial (in the sense of combative) the hearings become...

Reflecting on my experiences of New York, England and Victoria, it seems that the more a mental health court or tribunal is inquisitorial and takes a critical, questioning approach to the service's evidence, the less legalistic and adversarial (in the sense of combative) the hearings become because the patient's lawyer is no longer compelled to perform that function in full. Rather than the patient's lawyer having to question the doctor at length (which may create the impression of an entrenched 'us against them'), if the evidence is overtly and robustly scrutinised by the judicial decision-maker, the scrutiny becomes more neutral and also instils confidence in the patient that the decision-maker is approaching the matter – and the restrictions on their rights – seriously.

Irrespective of consumers' attitudes towards legal advocacy and hearings in other jurisdictions, it is important that Victorian consumers' views are sought regarding what they want from their lawyer, including preferred advocacy styles. In 2008, the (Victorian) MHLRC produced a detailed report on patient experiences of mental health hearings.³⁶¹ Beyond reflecting on this report, VLA has not traditionally sought direct consumer input into its services (aside from within individual lawyer-client relationships). However, following the commencement of the new MHA, MHDLC has made more concerted efforts in this regard. It commissioned an independent agency to talk with recent clients about our MHT advocacy approach, and preliminary reports suggest that our clients value and appreciate what we are doing. More recently, VLA has employed a 'senior consumer consultant', who commenced on 15 September 2015. This is an entirely new position which will work with both MHDLC and IMHA to develop a community engagement strategy, and will work with management to continue consumer involvement in all aspects of our mental health advocacy services.

RECOMMENDATIONS AND IDEAS

- ▶ Encourage the MHT to take a stronger approach to fair hearing concerns, especially regarding the late provision of reports, listings and notice provided for hearings.
- ▶ Encourage the MHT to take a more critical, inquisitorial approach to clinical evidence during hearings to obviate the need for lawyers to do so, which will reduce the level of adversarialism and perceived conflict in hearings.
- ▶ Establish a protocol with the President of the MHT for referring identified questions of law to the Supreme Court under s 197 of the MHA.
- ▶ Explore reshaping the MHDLC duty lawyer service model to allow greater hearing preparation time.
- ▶ Continue to engage with consumers/service users to validate and strengthen MHDLC's approach to legal advocacy.
- ▶ Bring all relevant stakeholders, including consumers/service users, together to establish a shared understanding of what constitutes quality legal representation for MHT hearings.

³⁶¹ Vivienne Topp, Martin Thomas and Mim Ingvarson, *Lacking Insight: Involuntary patient experience of the Victorian Mental Health Review Board* (Mental Health Legal Centre, 2008).

3C. PROTECTING RIGHTS IN ADMINISTRATIVE CONTEXTS: HOSPITALS AND CLINICIANS

How are administrative decision-makers relevant to rights protection?

Most mental health laws establish various roles and positions (such as ‘authorised psychiatrists’ and ‘responsible clinicians’) and give the people occupying those roles, usually psychiatrists or senior hospital administrators, the administrative (rather than judicial) power to make certain decisions in relation to compulsory patients. In this report, the people *other than tribunal members* who are empowered under mental health laws to make these decisions are collectively referred to as **administrative decision-makers**.

Administrative decision-makers play a broad and extremely significant role throughout systems of detention for compulsory mental health treatment. Firstly, they are gatekeepers to the system because they are the ones who make the initial decision to detain a person for compulsory treatment.³⁶² Then, once a person has been made a compulsory inpatient, administrative decision-makers are typically empowered or required to make certain further formal decisions in respect of that person, including:

- Whether, once admitted, the person should continue to be detained as a compulsory inpatient;³⁶³
- Whether they should be forced to accept treatment against their wishes and, if so, what treatment;³⁶⁴
- Whether they should be treated in seclusion and/or physically restrained;³⁶⁵
- Whether they can have periods of leave from the hospital;³⁶⁶ and
- Whether they should be transferred to a different hospital.³⁶⁷

Each of these decisions has a significant impact on human rights. Accordingly, the way in which administrative decision-makers go about exercising their decision-making functions will significantly influence the extent to which a person’s human rights and dignity are limited or protected during the course of their detention for compulsory treatment.

In addition to formal decisions, the general attitudinal culture, policies and conditions within a mental health service, which are created and influenced by administrative decision-makers and other staff, will also have a significant impact on a person’s experience of compulsory treatment. It may be that what is considered a small or incidental matter by the service (such as having to ask for permission to make a coffee or being observed during a bath) creates a greater sense of indignity and rights violation than the overarching decision to subject the person to compulsory treatment, particularly if there are multiple such events.

Quite aside from what the law permits or requires, I know from my experience in Victoria that a number of practical, operational and attitudinal factors may push against respect for human rights by administrative decision-makers and mental health services when a person is detained in a closed environment:

- Lack of knowledge or an incorrect understanding of the law, particularly where staff members are inexperienced and/or there is a high turnover of staff;
- Models of care that focus on a person’s perceived ‘best interests’, particularly clinical best interests, which are not informed by a rights framework or a holistic conception of personal interests;
- Lack of motivation and/or insufficient staff resources to spend the time required to gather relevant information and properly engage with the person in the decision-making process;
- Imprecision and conservatism in risk assessment;
- Limited risk appetite (whether for personal or organisational reasons) and other attitudinal influences on clinicians and mental health service managers, including stigma against mental illness;

³⁶²

In Victoria, this is done by way of an assessment order followed by a temporary treatment order: see *Mental Health Act 2014* (Vic) Part 4 Divisions 1 and 3.

³⁶³

Psychiatrists have a duty to release a person from detention and compulsory treatment as soon as they determine that the criteria no longer apply, see eg *Mental Health Act 2014* (Vic) s 61.

³⁶⁴

See eg *Mental Health Act 2014* (Vic) s 71(3).

³⁶⁵

See eg *Mental Health Act 2014* (Vic) Part 6.

³⁶⁶

See eg *Mental Health Act 2014* (Vic) s 64.

³⁶⁷

See eg *Mental Health Act 2014* (Vic) s 65.

- Pressure by family members, the media, politicians and/or the community to maintain restrictions; and
- Inadequate resources to provide best practice rehabilitation and less restrictive, community-based services and supports;³⁶⁸
- Key performance indicators and other standards which indirectly demand processes and outcomes that are inconsistent with a human rights approach in order to meet targets and/or maintain funding;³⁶⁹ and
- Being hidden from public view and subject to limited external scrutiny.

These factors may increase and prolong restrictions on rights in a way that is unjustified. For instance, in England, the CQC has noted that, due to bed pressures, some people who would be happy to comply with mental health services on a voluntary basis have nevertheless been subjected to formal detention orders under the MHA which restrict their rights, simply in order to secure a bed for them³⁷⁰ (see also ‘The importance of positive rights and adequate community services’ in Part 4B below). In addition, research indicates that institutional models of care provided in closed environments increase the risk of rights abuses.³⁷¹

Therefore, lawyers seeking to protect the human rights and dignity of compulsory inpatients need to look beyond the formal judicial contexts to the places where administrative power is exercised and find ways to influence and shape rights compliance in this context.

Some of the factors listed above are matters which lawyers can seek to influence or counteract in respect of individual administrative decisions, through insistence on fair processes, cogent evidence and a proper application of the law (much like in judicial decision-making contexts). However, others factors reflect much more complex structural or systemic issues which cannot be remedied in respect of an individual decision. In this section of the report, I focus on how lawyers can directly and indirectly influence administrative decision-makers in respect of the specific decisions they are empowered to make. I discuss lawyers’ efforts to shape the broader systemic factors which are beyond an individual decision-maker’s control separately in Chapter 4 below.

In conducting this part of the research, I explored:

- Whether and how lawyers seek to protect their clients’ rights by advocating directly in relation to specific administrative decisions;
- Whether lawyers use other strategies to influence administrative decision-makers in order to indirectly protect their clients’ rights;
- How lawyers can contribute to the creation of, and reinforce, rights-respecting conditions and cultures within mental health services; and
- Whether people thought that administrative decision-makers and the culture of mental health services in their jurisdiction were rights-respecting and, if so, what they thought were the most significant factors contributing to this.

Legal advocacy in relation to specific administrative decisions

In many areas of law, lawyers only participate in advocacy in formal judicial contexts. However, as explained above, the non-judicial decisions made in respect of compulsory inpatients by clinicians and other administrative decision-makers call out for advocacy because of the tremendous impact which these decisions have on the person concerned.

The manner in and extent to which lawyers directly advocate on behalf of their clients in relation to specific administrative decisions, such as compulsory treatment and the granting of leave, varies considerably between New York and England because of their respective legal frameworks and legal service models in operation. While English lawyers play a limited role, MHLS lawyers are significantly aided in their ability to scrutinise and influence key administrative decisions, particularly decisions in relation to compulsory treatment, because the *Mental Hygiene Law* establishes processes that not only permit but mandate their notification and participation.

³⁶⁸ Many people I spoke with noted that lack of community accommodation to which a person could be discharged resulted in people being detained for far longer than was clinically necessary – see Chapter 4 below.

³⁶⁹ For instance, in January 2015 it was revealed that a major Melbourne health service had issued a directive to staff to discharge at least three patients from each psychiatric ward every day, regardless of their progress: Patrick Hatch, ‘Monash Health U-turns on compulsory discharge of mental health patients’, *The Age* (23 January 2015). Other services may require the average length of acute psychiatric admissions to be kept below a certain number of days. These arbitrary requirements limit the willingness and ability of treating teams to take the time necessary to engage in meaningful discussions with their patients about their experience of and preferences for treatment, and limit the range of treatments which can be trialled. They also mean that people may be discharged prematurely with inadequate supports.

³⁷⁰ CQC, *Monitoring the Mental Health Act in 2013/14*, above n 82, 46.

³⁷¹ Frawley and Naylor, above n 21, 67.

Direct participation in formal 'treatment over objection' processes: New York

In New York, a psychiatrist is not empowered to administer a treatment they consider clinically appropriate simply because the person is subject to a compulsory treatment order. The questions of whether and what treatment can be forced on a compulsory inpatient are subject to a formal, two-stage process and are ultimately decided by the Supreme Court. It is part of the MHLS' statutory role to provide legal representation at both stages.

Stage 1: administrative review³⁷²

If a psychiatrist wants to treat a compulsory patient against their wishes, an 'administrative review' is first required, at which a different psychiatrist evaluates whether the person needs medication over their objection and, if so, which medication. The MHLS will attend and represent their clients at these administrative reviews.

In terms of how well these administrative reviews work, MHLS principal attorney Sara Rollyson was somewhat ambivalent:

I think people get listened to, it depends on the case. Sometimes it does feel a little bit routine and we try to make sure they are not and that the client is being heard, that is one of the reasons we are there. We will meet the client beforehand and we will review the chart beforehand and get a handle on what is going on and what kind of questions they are going to be asked. We will let the client know what is going on, and I will always tell the client, 'The doctor is going to ask you some questions so be honest and keep in mind why they are asking you these questions', and sometimes it works and sometimes it doesn't.

Stage 2: court hearing

If the administrative review determines that the person needs a particular treatment but the person continues to object, the psychiatrist must then apply to the Supreme Court for permission to treat the person over their objection with those recommended treatments; the person cannot be treated against their wishes until the court has decided the application. These hearings were mandated following the New York State Court of Appeals case of *Rivers v Katz* in 1986.³⁷³ A treatment over objection application cannot be granted unless the State establishes that the person lacks the capacity to make the decision and the proposed treatment is the least restrictive option:

Rivers established a procedural due process standard for medication over objection, requiring a judicial finding that the patient lacks the capacity to make competent decisions concerning treatment. This is a judicial determination, not a clinical determination, and recogni[s]es that there is a cogni[s]able deprivation of liberty resulting from a decision to forcibly medicate a person who has been involuntarily committed.³⁷⁴

Back in 1997, after a long-term, observational study of treatment over objection hearings, Tina Minkowitz expressed considerable criticism of the operation and efficacy of these hearings:

With the exception of [one particular judge], the judges are overwhelmingly predisposed to agree with the psychiatrists' conclusions. Psychiatrists advocating forced medication are not closely questioned as to how they made the determination that a person lacks capacity. They are not made to specify in detail the numerous risks associated with neuroleptic drugs, nor are they usually required to detail the benefit sought or their weighing of risks versus the benefits for this particular person. At times evidence relating to the person's dangerous behavior is presented over the objections of attorneys that it is irrelevant and prejudicial. The first and most colorful evidence presented is typically of the person's mental illness, admitting circumstances and diagnosis. Often it is not clear how a particular piece of evidence is meant to relate to either capacity or the risks and/or benefits of the drug. Most often, closing arguments are neither offered nor required.³⁷⁵

Sara Rollyson felt that 'a lot has changed in the 18 years since [this study] was written' and that the 'standard is improving all the time'. However, it is objectively true that it remains hard for a lawyer and their client to defeat an application to treat the person over their objection.³⁷⁶

³⁷² Administrative reviews are also held in relation to proposed transfers between hospitals and from acute to long-term care: 14 NYCRR 517.4.

³⁷³ 67 NY2d 485 (1986).

³⁷⁴ New York State Office of Mental Health, *Kendra's Law*, above n 37, 38.

³⁷⁵ Above n 272.

³⁷⁶ This is discussed in Perlin and Cuculo, above n 178, ch 8.

Nevertheless, the process at least creates clarity around what particular treatment is sought and why. The scheduled hearing also provides an opportunity for lawyers to negotiate with clinicians on the 'steps of court' to better take into account their clients' concerns about particular treatments. This is something I saw having an impact on the day I attended the hearings at BPC, when in at least one case the hospital withdrew certain proposed medications from its application in response to concerns raised by the MHLS.

Limited scope for direct legal advocacy: England

In contrast to New York, lawyers in England rarely advocate directly in relation to specific administrative decisions. This appears to be because of the predominantly informal and unseen processes through which these decisions are made, as well as the limitations on their role corresponding to the scope of legal aid funding available.

Advocating for release at hospital managers' hearings

The only formal administrative decision-making process in which English mental health lawyers play a role is at hospital managers' hearings, which is an opportunity to try to persuade the hospital to release the person from their compulsory treatment order.

Patients are entitled to be legally represented at hospital managers' hearings and the MHLA encourages lawyers to attend these hearings with their clients as 'they can be useful preparation prior to Tribunals'.³⁷⁷ However, for Legal Aid Agency purposes, a hospital managers' hearing only constitutes an attendance on the client as part of preparation for an MHT hearing (rather than an appearance in and of itself) and thus does not attract a separate fee, so many lawyers do not routinely attend these hearings with their clients.

Lawyer John O'Donnell noted that some hospital managers' hearings are 'shambolic' but others, where the hospital managers are well trained, operate just like an MHT hearing. Peter Edwards' staff noted that, although they do not start from a presumption that the patient should remain detained, the discharge rates at hospital managers' hearings are even lower than at MHT hearings. They were accordingly somewhat sceptical of the value of these hearings, noting that patients do not often ask for them, but said they would stop short of saying they are pointless. They felt that it was important in a system with no continuous right of appeal to the MHT to have some form of scrutiny on demand, and that the hearings act as a prompt for doctors to consciously re-examine the application of the criteria.

Compulsory treatment and other administrative decisions

In England, while there is a statutory test and human rights standards which must be applied before a clinician can decide to administer a particular treatment to a compulsory inpatient, the decision-making power rests with that individual administrative decision-maker. The decision is made behind closed doors, with no clear decision-making forum in which the patient or their lawyer can participate. The same is true of other administrative decisions, such as the granting of leave from hospital and transfers between hospitals.

As the Legal Aid Agency will only remunerate private lawyers for certain discrete legal tasks (like representation at an MHT hearing), the funding model in England does not encourage lawyers to advocate on behalf of their clients in relation to administrative decisions made within hospitals. While lawyers do sometimes raise issues in writing on behalf of their clients, such as drawing the service's attention to a patient's wishes regarding a particular treatment and concerns about side effects, Peter Edwards' staff noted there is not much they can do about those issues without funding. Sue Eades, manager of IMHA services at Broadmoor Hospital, also noted that lawyers generally do not advocate on behalf of their clients regarding ward issues and obtaining leave. Instead, lawyers usually refer such issues to IMHAs for assistance.

³⁷⁷ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 43.

... some hospital managers' hearings are 'shambolic' but others, where the hospital managers are well trained, operate just like an MHT hearing.

– English lawyer John O'Donnell

Role of IMHAs in influencing administrative decision-making

Recognising the very limited role that lawyers (are funded to) play in these matters, IMHAs were established in England to influence practice and promote human rights behind closed doors by supporting compulsory inpatients to understand and participate in the decisions that would otherwise be made solely by clinicians or others around them. The rationale for IMHA services is explained as follows:

Self-determination is a fundamental principle, enshrined in law and in health and social care policy. With its origins in the service user movement, advocacy serves to promote greater self-determination and empower people to have greater control and choices in their engagement with services. The importance of the active participation of people in planning their care and treatment while detained under the [MHA] is one of the key principles on which the [MHA] rests. Thus, IMHA services were introduced by the [2007 amendments to the MHA] to safeguard the rights of people detained under the [MHA] and to enable them to exercise their rights through supporting participation in decision-making.³⁷⁸

The roles and functions of lawyers and IMHAs are seen as very distinct; Sue Eades said that IMHAs 'have a completely different remit from the lawyers'. IMHAs are typically more accessible to patients than lawyers and play a more active role in advocating with treating teams around a broader range of patient concerns, particularly treatment-related issues.³⁷⁹ IMHAs will also come to ward meetings and 'care programme approach'³⁸⁰ ('CPA') meetings.³⁸¹ Peter Edwards' staff noted that IMHAs will typically see their clients more than they do (and so can be useful in feeding relevant information back to them following CPA meetings).

Ian Callaghan explained the difference between a lawyer and an IMHA from a service user perspective:

I think an IMHA is more useful in helping with questions about care and treatment rather than during discussions about discharge or other legal situations. Lawyers for the big things, IMHAs for the more detailed issues about day-to-day care...

I don't think lawyers could or should get involved in the minutiae of day-to-day care. I think it would be beyond their expertise and would prove very expensive indeed!

In terms of influence, Ian felt that lawyers 'probably carry more weight' than IMHAs when raising issues with doctors. While Sue felt that this 'depends on the issues', she said that, as IMHAs typically know their clients very well, 'generally our view will be valued'.

Reflections

It is clearly more resource intensive to have a system like New York's, with formal processes and additional hearings regarding specific matters such as compulsory treatment decisions. These processes also delay the making and implementation of a decision. As noted in Part 3B above, treatment over objection hearings are given low priority in busy court lists. This means that a considerable period of time may pass before a compulsory inpatient is forced to accept treatment which may ultimately be necessary to assist their recovery and allow them to be discharged from hospital.

³⁷⁸ Karen Newbigging, Mick McKeown and Karen Machin, 'The right to be heard: independent mental health advocacy services in England', *Mental Health Today* (September/October 2012).

³⁷⁹ Sheena Ebsworth, Samrat Sengupta.

³⁸⁰ The CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. It involves the development of a formal written care plan (following an assessment of needs) that outlines any risks, including details of what should happen in an emergency or crisis. A CPA care co-ordinator will be appointed, who must make sure that the CPA care plan is reviewed regularly. A formal review must be made at least once a year. See NHS Choices, 'Care Programme Approach' <<http://www.nhs.uk/conditions/social-care-and-support-guide/pages/care-programme-approach.aspx>>.

³⁸¹ Sheena Ebsworth, Samrat Sengupta.

However, from a rights perspective, bringing these issues out from behind closed doors into a public hearing guarantees that decisions will be properly considered. As Michael Perlin noted:

Ward psychiatrists demonstrate a propensity to equate incompetent with ‘makes bad decisions’ and to assume, in the face of statutory and case law, that incompetence in decision making can be presumed from the fact of institutionalization. Without a lawyer there to question this presumption, it is far less likely that the actual law (that such presumption cannot be assumed) will be enforced.

Such processes also lessen the influence which an individual treating psychiatrist has in determining the outcome.

Having formal and transparent hearings, coupled with procedural safeguards and a statutory duty to appear, enables the MHLS to scrutinise and influence both the process and outcome. This has the potential to better ensure that statutory and human rights will be properly considered and respected when these important decisions are made.

There was nevertheless some ambivalence among MHLS lawyers as to their ability to influence these processes. This was also evident in Washington DC, another jurisdiction which requires administrative hearings to be conducted in relation to compulsory treatment in certain circumstances (see box below). Clearly, mere presence and the opportunity to be heard is not necessarily sufficient to genuinely influence outcomes and does not, in and of itself, guarantee that the outcome will be rights compliant.

382

Code of the District of Columbia § 7-1231.08.

383

Ibid § 7-1231.08(c):

- (1) ‘Written and oral notice to the consumer of available advocacy services;
- (2) ‘The right to a meeting convened by a neutral party within the Department for the purpose of reviewing the necessity for involuntary administration of medication;
- (3) ‘The right of the consumer to not less than 48 hours prior notice of any such meeting;
- (4) ‘The right of the consumer to be present and have representation during any such meeting;
- (5) ‘The opportunity, at the meeting, for the consumer and his or her representative to present information and to discuss the necessity of medication with the physician seeking to administer it;
- (6) ‘A written decision by the neutral party, within a period of time established by the Department, regarding whether the medication may be administered over the objection of the consumer. This decision shall be valid for no more than 30 days if it authorizes the involuntary administration of medication;
- (7) ‘The right to appeal the decision of the neutral party to an independent panel consisting of 3 persons appointed by the Director and convened within 72 hours. The members of the panel shall not be affiliated with the individual consumer, the provider, or the physician seeking to administer the medication, but shall include:
 - A. ‘A board-certified psychiatrist;
 - B. ‘A licensed practitioner; and
 - C. ‘A consumer, or if unavailable, a consumer advocate; and
- (8) ‘The right to have any decision of a neutral party that is appealed to the panel stayed pending a determination by the panel regarding whether the decision should stand or be overturned.
- (9) ‘A consumer’s refusal to consent to medication on the basis of a valid religious objection shall not be overridden absent a specific court order requiring the provider to administer the medication.
- (10) ‘Family members and personal representatives to whom the consumer has authorized release of information in accordance with Chapter 12 of this title, shall be notified whenever a provider involuntarily administers medication pursuant to subsections (c) or (d) of this section.’

Compulsory treatment processes in Washington DC

In Washington DC, a person generally cannot be given mental health treatment without their informed consent. However, a mental health service may administer medication to an ‘incapacitated consumer’ if approval for that treatment has been given through an ‘approved administrative procedure’.³⁸² Instead of the treating psychiatrist making the decision, an ‘independent treatment panel’ comprising a psychiatrist, a psychologist and a patient advocate conducts hearings at the hospital to decide whether the person lacks capacity and thus whether forced treatment can occur.

Despite the minimum safeguards set out in the statute,³⁸³ including the fact that patients are entitled to be legally represented at these hearings, Kim Clark from the DCPDS MHD described this as a ‘kangaroo’ process. A patient advocate I met at St Elizabeths told me that, in the two years she had sat on the independent treatment panel, she had never seen treatment *not* be ordered. She said the decision of the panel has to be unanimous, so she gets told, ‘We’ll sit here all day if necessary until you agree with us’. Nevertheless, peer advocate Yvonne Smith (who does not sit on the independent treatment panel) thought that lawyers could make a difference at these hearings and wanted to see lawyers advocating more in these hearings.

In Victoria, like in England, administrative decisions such as compulsory treatment decisions are made by individual clinicians behind closed doors. Despite MHDL’s regular, on-site presence at hospitals, it is still very challenging for us to observe or influence administrative decision-making within services. The new *Mental Health Act 2014* introduced greater clarity and restrictions around an authorised psychiatrist’s power to compel a compulsory patient to accept a particular treatment. However, it is still much harder for lawyers to support their clients in this process than it is for MHLS lawyers in New York, where there is both a clear administrative review and judicial hearing on the subject if necessary. Exposing these decisions to external scrutiny would improve compliance with the law. However, it is currently next to impossible to scrutinise a particular treatment decision (and consequently the true need for the overarching treatment order) because, in MHDL’s experience, there are inconsistent and often poor practices among Victorian clinicians of explicitly documenting which treatments are being provided with a person’s consent and which are being provided pursuant to their compulsory treatment powers, along with the reasons for any such decision.

While MHDL lawyers have been limited in their ability to scrutinise compulsory treatment decisions, one recent development should assist: VLA commenced delivering Victoria's first ever IMHA services on 31 August 2015, which will perform a similar function to the English IMHA services. Victorian IMHAs will play an important role in spending time behind closed doors, supporting patients in their decision-making and directly influencing the practical application of the MHA. If Victorian mental health services get used to IMHAs seeking information about and participating in compulsory treatment discussions, and reframing these decisions as a careful exercise of legal power, it paves the way for lawyers to enter these discussions more easily where it is identified that they are not being conducted in accordance with the prescriptive requirements of the MHA. IMHAs will be well placed to quickly refer decisions that seem unfair or incorrect to lawyers for protective legal advocacy. It is therefore important that there is a strong communication pathway and regular dialogue between VLA's MHDL and IMHA programs, and that IMHA advocates are trained in what to look out for in terms of statutory and human rights compliance. It may also be helpful for Victoria's new IMHA advocates to learn more about the challenges and opportunities with this sort of advocacy from their English counterparts.

Influencing administrative decision-makers through advocacy in judicial contexts: England

While English lawyers play a limited role in advocating directly to administrative decision-makers on behalf of their clients to obtain a specific outcome, they do regularly advocate in two different judicial contexts in order to influence administrative decision-makers.

These strategies are not replicated in New York because of the differing legal frameworks. The MHLS does use litigation to improve conditions and services in hospitals but, because it is predominantly aimed at addressing systemic issues rather than influencing administrative decisions in respect of particular individuals, it is discussed in Part 4C below.

Seeking MHT recommendations

At an MHT hearing where detention is confirmed, the MHT may make statutory recommendations under s 72(3) of the MHA with a view to facilitating leaves, transfers and discharge. Accordingly, if it seems that the mental health service is not adequately facilitating progress towards release, even if it appears unlikely that their client would be discharged by the MHT, a lawyer may nevertheless advise their client to apply for an MHT hearing in order to request certain recommendations to push the process along (however, such advice would need to take into account the fact that no subsequent application could be made to the MHT in the same eligibility period). Of course, lawyers can also seek these recommendations at the conclusion of an unsuccessful MHT hearing, even if the hearing was not triggered for that purpose.

Upon making recommendations, the MHT will usually set a date at which they will consider the need to reconvene. Lawyers are encouraged to write to the MHT at this point to explain whether the recommendations have been complied with and whether any further pressure by the MHT should be brought to bear.³⁸⁴

Specific recommendations by the MHT will influence clinicians to speed up or alter a person's trajectory towards release from hospital. Accordingly, by influencing the MHT to make recommendations and to reconvene to explore any non-compliance, lawyers can influence and shape administrative decisions made by the service.

Nevertheless, MHT recommendations are ultimately not legally enforceable. In an unsuccessful challenge to an MHT decision not to reconvene following the non-implementation of a recommendation, the Upper Tribunal explained that the MHT's statutory recommendation powers operate 'by moral pressure and moral authority',³⁸⁵ while the MHT 'has no power to enforce the recommendation and is not reconvening for that purpose[, it] has the power to embarrass the authority into explaining its thinking or, possibly, into compliance'.³⁸⁶

It is also possible to seek informal, non-statutory recommendations from the MHT.³⁸⁷

³⁸⁴ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 31.

³⁸⁵ *RB v Nottinghamshire Healthcare NHS Trust* [2011] UKUT 73 (AAC), [12].

³⁸⁶ *Ibid* [16].

³⁸⁷ Including in restricted cases: MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 33.

... judicial review has made a significant contribution to the development of a law-abiding and rights-compliant decision-making culture among English clinicians...

Judicial review and other direct legal challenges

While English lawyers do not play a formal role in the initial administrative decision-making process, they can directly challenge the lawfulness and human rights-compatibility of decisions made by a clinician or hospital by seeking judicial review or litigating a breach of the *Human Rights Act 1998* (UK) in the High Court. In July 2015, the UK Lord Chancellor and Secretary of State for Justice Michael Gove described the importance of judicial review as follows:

Without the rule of law power can be abused. Judicial review is an essential foundation of the rule of law, ensuring that what may be unlawful administration can be challenged, potentially found wanting and where necessary be remedied by the courts.³⁸⁸

Exposing administrative decisions and decision-making processes to scrutiny and comment in the higher courts is thus a very direct way for a lawyer to seek to protect their client's rights, because any unlawful or improperly made decision can be set aside by the court.

In addition, these legal challenges serve an important reflective and educative function. Decision-makers are not simply exercising an unfettered discretion or clinical judgment when deciding, for instance, whether a person should be granted leave, transferred to a different facility or given treatment against their wishes. Exposure to High Court scrutiny reminds and reinforces to decision-makers that these decisions involve the exercise of a confined public power, which must be exercised properly and within the bounds of the rules set by Parliament, human rights instruments and the common law.

Furthermore, even if the challenges do not ultimately proceed, Tam Gill and others identified that the *threat* of such legal actions remained very important. Being able to credibly say that a decision is wrong at law for particular reasons and remind the decision-maker that legal action can be taken to overturn their decision is a very powerful negotiating tool to secure rights-compliant outcomes for individual clients.

Everyone who I asked in England confirmed that judicial review has made a significant contribution to the development of a law-abiding and rights-compliant decision-making culture among English clinicians, which shapes how they act in practice. MHA administrator Sheena Ebsworth said that concern about being sued and consequently losing money and/or reputation were motivating forces for human rights compliance. She noted that judicial review and/or actions for breaches of the *Human Rights Act* had arisen in relation to a range of decisions, including specific compulsory treatment decisions, compulsory treatment where the person has capacity, the use of long-term segregation or seclusion, delays in hearings and the application of blanket security policies.

The clinicians I spoke with were also conscious of the readiness with which lawyers and courts would scrutinise their decisions. Dr Samrat Sengupta said it was 'not uncommon' for lawyers to get injunctions with a view to judicial review proceedings, and that it was 'not that uncommon' for a compulsory treatment decision to be subjected to judicial review. If a patient raises concerns with him about a potential treatment, he said he will delay commencing the treatment until the patient can get legal advice and decide if they want to get an injunction pending judicial review.

³⁸⁸ Ministry of Justice (UK), *Consultation Paper: Reform of Judicial Review: Proposals for the provision and use of financial information* (2015) Ministerial Foreword.

The lawyers felt that a readiness to undertake judicial review (where there is merit to do so) was an important part of the legal service to be provided to individuals, and that a mental health legal service must do more than merely provide representation in first-instance MHT hearings in order to protect their clients' rights. Barristers Aswini Weeraratne QC and Neil Allen also identified false imprisonment claims, other common law claims and breaches of the *Human Rights Act* as important auxiliary actions which mental health and disability lawyers should be capable and willing to undertake. Similarly, John O'Donnell felt that it is wrong for a firm to specialise in pure mental health law without a strong practice in human rights and administrative law as well, which his firm also does. Richard Charlton also said that he has always done a lot of judicial review work. The use of anti-discrimination law in other issues associated with compulsory treatment, such as access to housing and access to legal representation for persons lacking capacity to instruct, was also seen as an important legal device to explore.³⁸⁹

It is important to note that, like appeals to the Upper Tribunal, High Court judicial reviews, County and High Court damages claims (for torts such as negligence and false imprisonment) and breaches of human rights cases are not considered or treated by lawyers or the Legal Aid Agency as 'strategic litigation'; they are simply the correct follow-up legal action to take on behalf of an individual whose rights are not being respected or who is subject to a decision that is legally incorrect. Indeed, rather than requiring a greater cautiousness or confidence in the merits of the case, the Lord Chancellor's official guidance on the availability of legal aid funding states that,

[because] it can be said to be in the general public interest for public authorities to act lawfully... claims against public authorities alleging abuse of power or significant breach of human rights and applications for judicial review are subject to less strict criteria than the general merits criteria.³⁹⁰

The criteria for legal aid funding for judicial review and breaches of human rights matters are set out at Appendix 5.

There have been a number of reforms to English judicial review processes in recent years,³⁹¹ 'many of [which] have been designed to deter claims and to introduce new procedural hurdles for claimants, including by restricting access to legal aid and sources of third party funding'.³⁹² The Legal Aid Agency funded 25 mental health-related judicial review matters in the 12 months to March 2015 (a small proportion of the 3766 judicial review matters funded in that time),³⁹³ but only six in the six months since then.³⁹⁴ Like most of the people I spoke with, Peter Edwards lamented that changes to legal aid had cut down on judicial review considerably, because 'that was how we kept the executive in check'. Speaking at a seminar I attended in London on 4 June 2015, Sir Stanley Burnton, who chaired the JUSTICE working party which produced the report, *Delivering Justice in an Age of Austerity*,³⁹⁵ said that, among all the legal aid funding cuts and austerity measures, the 'retrenchment of judicial review' was of greatest concern because 'restricting people from accessing the courts prevents access to justice and removes incentives for decision-makers to comply with the law'.

Reflections

Unlike England's, Victoria's MHT has no power to make recommendations to services regarding matters like leave. Notwithstanding the advice in the MHT's own guide to 'solution-focused' hearings,³⁹⁶ MHDL has found that MHT members vary considerably in their willingness to engage in discussions about or comment on issues such as specific treatments and leave which do not directly relate to the specific question which the MHT is tasked with deciding (namely, whether the criteria for compulsory treatment apply); some members expressly refuse to entertain discussion about these matters. The MHT's lack of formal jurisdiction coupled with its variable approach makes it hard to gain traction in influencing clinicians towards a more rights-respecting approach to these matters, which are of considerable importance to the people being detained and are often intrinsically linked to the ongoing need for and duration of their detention.

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Aswini Weeraratne QC, Sophy Miles, Peter Edwards.

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Lord Chancellor's Guidance under section 4 of Legal Aid, Sentencing And Punishment Of Offenders Act 2012 (2014) 10.

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For instance, in 2012, a new procedure was introduced whereby a person seeking judicial review must first apply to the administrative court for permission to bring the case. A judge will decide this on the papers, although if permission is refused, the person can ask that the decision be reconsidered at an oral hearing. In 2015, the *Criminal Justice and Courts Act 2015* (UK) introduced a new 'materiality' threshold for judicial review applications, which requires the High Court to refuse to grant permission or relief 'if it appears to the court to be highly likely that the outcome for the applicant would not have been substantially different if the conduct complained of had not occurred' (s 84), and created a new duty on the court to award costs against interveners in any case where specified criteria are satisfied (s 87).

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Bingham Centre for the Rule of Law, JUSTICE and the Public Law Project, *Judicial Review and the Rule of Law: An Introduction to the Criminal Justice and Courts Act 2015, Part 4* (2015) 1.

393

Ministry of Justice (UK), *Legal Aid Statistics*, above n 134, 34.

394

Ministry of Justice (UK), *Legal Aid Statistics in England and Wales: July to September 2015* (2015) 31.

395

JUSTICE, above n 156.

396

A Guide to Solution-Focused hearings in the Mental Health Tribunal, above n 283.

One of the most critical ways in which lawyers were identified as having contributed to building a human rights-respecting decision-making culture in England was by bringing direct legal actions, or being prepared to do so when necessary, to challenge administrative decision-makers and hold them to account. In contrast, there has been a dearth of direct legal challenges to decisions of clinicians and mental health services in Victoria. We are admittedly disadvantaged compared to other jurisdictions by the absence of a direct cause of action under our Charter.³⁹⁷ Even so, while England bemoans having only 25 mental health-related judicial reviews in the last year, there have been only a few superior court decisions of any legal type regarding the administrative powers of mental health clinicians in Victoria in the thirty years since modern mental health laws were introduced.³⁹⁸ Furthermore, notwithstanding the significant opportunities for advocacy relating to the new standards and processes under the Mental Health Act 2014, no judicial review cases have been heard since that Act commenced in July 2014.³⁹⁹

Reasons for MHDL's limited superior court actions against administrative decision-makers include:

- Competing workload pressures;
- Only recently developed administrative law proficiency within MHDL; and
- The absence of a specific funding guideline for judicial review matters.

Currently, a judicial review matter can only be funded by VLA under the 'public interest and strategic litigation' guideline,⁴⁰⁰ which requires demonstration of a significant public benefit, irrespective of the significance of the decision for the individual affected. The process for seeking funding under this guideline is also quite involved and requires personal approval from the managing director of VLA.

Nevertheless, given practising lawyers, barristers, clinicians, administrators and academics in England all identified the crucial role which legal challenges to administrative decision-making (and the credible threat thereof) play in educating and motivating services towards statutory and human rights compliance, Victorian lawyers should look to do more in this area.

Shaping rights-respecting conditions and culture through presence and relationships

While facilitating judicial oversight was identified as contributing to a rights-respecting culture in England, lawyers can contribute to the creation of, and reinforce, rights-respecting conditions and cultures within mental health services in other ways.

In New York, due to their mandate and very regular presence on site within hospitals, MHLS lawyers have considerable opportunities to interact with staff and to monitor, scrutinise and influence the practice and culture of mental health services. They frequently observe individual incidents and issues over time, and will raise concerns about what they see with staff. Their broad statutory mandate gives them standing to proactively raise issues even without direct instructions from a specific client:

[W]e are there to make sure:

- That the conditions in the wards are respected...
- That the clients are getting the treatment that they should get, meaning not that we are doctors or anything but if they are saying they are having a group now, that they are having a group [ie the treatment is actually taking place;]
- That the conditions in the ward are respectable;
- [That] people don't have to ask for toilet paper, which was a memo that I once had to write...
- That the sheets are clean and the ward doesn't reek, things like that.

Just making sure that everyone's human rights are respected. [We] do a lot of that as we are also an oversight agency.⁴⁰¹

³⁹⁷ Note the creation of such a cause of action was recently formally recommended: Michael Brett Young, *From Commitment to Culture - The 2015 Review of the Charter of Human Rights and Responsibilities Act 2006* (2015) viii.

³⁹⁸ *Murray and Anor v Director General, Health and Community Services Victoria and Ors* (unreported, 23 June 1995, Supreme Court of Victoria) (a habeas corpus matter); *Antunovic v Dawson & Anor* [2010] VSC 377 (a habeas corpus matter); *XX v WW and Middle South Area Mental Health Service* [2014] VSC 564 ('Patient X', a judicial review matter).

³⁹⁹ MHDL did commence a judicial review case against a mental health service in March 2015 but it was discontinued in September 2015.

⁴⁰⁰ This guideline states:
Legal assistance may be granted to a person for a legal proceeding that:
• is not otherwise covered by [VLA] guidelines; and
• carries significant public benefit by seeking to:
• clarify or test the scope of existing legal rights and duties; or
• challenge the accepted interpretation of legal rights and duties; or
• establish new legal rights and duties in the common law or under statute; or
• improve administrative decision making, and the efficiency and fairness of the justice system.

In deciding whether to grant legal assistance VLA must have regard to:
• the priority client groups in VLA's current Strategic plan; and
• the service priorities in VLA's current Strategic plan; and
• VLA's current strategic advocacy priorities; and
• whether the case is a good vehicle for dealing with the relevant issue of law; and
• the likely cost of the proceedings; and
• the merit of the legal argument proposed to be made including whether it is likely to succeed in the particular proceedings, expose an inequity in the law or form part of a larger strategic advocacy plan.

See VLA, 'Public Interest and Strategic Litigation' in VLA Handbook for Lawyers, above n 196.

⁴⁰¹ Sara Rollyson.

‘I would be standing in the line for coffee and they would be talking about abusing the clients and someone would say, “That is the lawyer behind you” and they would say, “I don’t care”. So that has changed.’

– Sara Rollyson, MHLS, New York

The MHLS’ ability to provide oversight is aided by its statutory powers, including to be granted access to all parts of the facility and all records necessary for carrying out their functions.⁴⁰² However, while adequately funded for all in-court representations, Lisa Volpe explained that insufficient funding and human resources does limit the extent to which the MHLS can proactively fulfil the investigative part of its mandate:

The mandate has expanded significantly over the years and, while we represent everybody... there are things that are included within the mandate like investigating abuse and mistreatment that probably get short shrift because there is another agency that is supposed to be reviewing all those circumstances, that’s the Justice Center... While that’s still part of our mandate, it’s just a lesser part because we can only do so much. Certainly when we see that there’s a problem we address it, but we’re not searching it out the way we might be with admissions and treatment over objection, we don’t pursue it in the same way... Similarly, we have the jurisdiction to reach out to everybody who’s in a group home or community residence and we simply don’t have the manpower for that, so what we do is we address problems if they come to us – if someone calls us we address it – but we’re again not looking every single day at every single person because we can’t.

At certain times, such as when they were preparing for their law suit against Kings County Hospital (see box ‘Fight to improve conditions at Kings County Hospital: *Hirschfeld vs New York City Health and Hospitals Corporation*’ in Part 4C below), MHLS staff consciously check hospital conditions. Generally, however, standards are monitored and maintained through MHLS lawyers just generally keeping an eye on things:

Now it’s more just being there, and also the clients are more likely to tell us what’s going on and we will look into it. So if the client says that, ‘This staff member snuck into my room and was doing whatever’, we will look into that. If they are claiming that the night staff are sleeping on the job and no one is awake, or if they are claiming that they are being abused or they are scared, if there is one client who is terrorising the whole unit and they fear for their safety, [we will look into] things like that.⁴⁰³

For the most part, the hospitals and staff are accepting and facilitative of the MHLS’ oversight role and are used to their presence. Sara Rollyson said that there are still some doctors who do not respect the MHLS’ role and ‘they think we are in their way, but for the most part I think they understand it and respect it as well’.

I just like to be a presence there. That way I can say to them, ‘Don’t hate us. Even though we are not necessarily working together we are not the enemy here either’. Just explaining what our role is here... I think it is also important for the staff to understand.⁴⁰⁴

However, the MHLS’ presence has not always been so welcome or had such an impact on staff at all hospitals:

The culture in [Kings County] Hospital when it was the old G building... I would hear people, literally... I would be standing in the line for coffee and they would be talking about abusing the clients and someone would say, ‘That is the lawyer behind you’ and they would say, ‘I don’t care’. So that has changed. I have been working there a long time. I know a lot of the staff. There are staff who respect you and some who don’t, just like any other job. Some staff understand what you do and some staff think you are working against them. I think for the most part they understand what our role is.⁴⁰⁵

⁴⁰² Mental Hygiene Law § 47.03(d).

⁴⁰³ Sara Rollyson.

⁴⁰⁴ Ibid.

⁴⁰⁵ Ibid.

... the hospitals [we] do not visit regularly ‘get very sloppy’...

– Patrick Reilly, NJOPD MHA, New Jersey

Sara Rollyson reported that the attitudes of Kings County Hospital staff towards lawyers have improved in recent years and that most staff now respect their role. Following the litigation against them, the new management are more open to communication with the MHLS than their predecessors were: ‘My opinion is that they can always do more but we do have some communication with them’.⁴⁰⁶ The MHLS now meets quarterly with the hospital to talk about issues that arise and they also have the mobile phone numbers of the managers in case they need to be contacted for urgent matters.⁴⁰⁷

The positive impact of regular, on-site presence and ongoing relationships between the legal service and mental health service was also noted in New Jersey. The NJOPD MHA offices are not co-located with the hospitals. However, NJOPD MHA staff providing services hold relationships with hospital staff; the investigators hold the strongest relationships because they are on site the most.⁴⁰⁸ Patrick Reilly said the simple fact of paying attention to what is going on helps. He noted that raising an issue is often enough to effect change. Patrick also said that the hospitals they do not visit regularly ‘get very sloppy’, but after six months of lawyers being regularly present there they will have ‘tightened up their practices’.

More formally, the manager of each NJOPD MHA regional office will develop a working relationship with the administrator and clinical staff and hold regular meetings to discuss issues arising in practice. Patrick Reilly also initiated quarterly meetings with the person who funds the hospitals, which provides the opportunity to raise issues with someone who has the power and motivation to directly influence change. He said that knowing the hierarchies and who wields power is important in order to influence practice.

The situation contrasts significantly with England. Firms that specialise in mental health work typically allocate cases so that a particular lawyer covers particular hospitals, which means that the lawyer will attend their hospitals fairly regularly and get to know staff there well. However, Katherine McCabe felt that MHLS lawyers have stronger relationships with hospital staff than English lawyers due to their institutional standing and constant presence, and are perhaps more likely to speak up if they observe something even if it does not directly relate to a client from whom they have specific instructions.

John O'Donnell described it as a ‘major defect’ in the English system of diffuse, privatised legal representation that no-one holds an organisational or institutional relationship with the detaining facilities, which would bring with it the standing to seek audience and dialogue about systemic issues. He said that he had tried to initiate forums of this nature in the past but they have come to nothing (see ‘Single vs disparate services’ in Part 5A below). MHA administrator Sheena Ebsworth said that where there is a good relationship between the lawyer and service, the lawyer will raise systemic issues with them informally ‘because they care’. However, John said that he when he has raised issues and suggested solutions to MHA administrators, they generally tell him they are too overworked and busy to do anything about it.

Reflections

While we have no statutory mandate, MHDL lawyers in Victoria are regularly present behind the closed doors of mental health facilities. We provide regular, in-reach legal advice services to at almost all inpatient units in Victoria and the same lawyers generally attend each unit each week, allowing us to become a familiar presence to both patients and staff. In this regard, our service model is far more similar to the MHLS’ in New York than to the private lawyers’ in England. However, in the absence of a formal mandated role or entitlement to enter the service, we need to work to maintain the current support for our presence from those who control access to the facilities and patients.

⁴⁰⁶
Ibid.

⁴⁰⁷
Ibid.

⁴⁰⁸
Patrick Reilly.

Through our regular, on-site presence and high volumes of work, MHDL has the opportunity to identify both individual administrative decisions and recurring practices that are not rights compliant. As the organisation with primary responsibility for providing mental health legal services across the state, we have accordingly sought to establish institutional relationships with the directors of mental health services in order to raise and address these issues. However, our efforts in this regard have, to date, been met with varying levels of interest and success.

Overall perceptions of administrative decision-makers

New York

I did not hear a great deal about lawyers' or service users' perceptions of specific clinicians and administrative decision-makers in New York. The few comments that were made were not particularly positive. However, as explained above, the powers of individual clinicians – particularly with respect to compulsory treatment decisions – are far more circumscribed in New York compared to other jurisdictions, which somewhat lessens their significance in the overall scheme.

England

In contrast, almost everyone I spoke with in England felt that most clinicians and administrative decision-makers are aware of the law and properly apply the law and human rights principles when making decisions. I was somewhat surprised by this generally positive rating given the more limited role which English lawyers play in relation to specific administrative decisions and the absence of a dedicated (statutory or otherwise) legal service being present and inquisitive in all hospitals. Because I was so intrigued, I decided to look in some detail at the other factors beyond the role of lawyers which were identified as having helped to create or maintain a rights-respecting culture in England (see 'Non-lawyer factors shaping statutory and human rights compliance by mental health services in England' below).

Tam Gill felt that the human rights of people diagnosed with mental illness in detention are on the whole respected, with a caveat in relation to people who lack capacity (see Part 3D below). She has noticed improvements over time since she has been practising in the field, including:

- A move to multidisciplinary teams which has reduced the primacy of narrow clinical interests in decision-making; and
- More deliberate and considered decision-making activity.

The psychiatrists I spoke with – Drs Samrat Sengupta and Richard Noon – both emphasised the need to ensure their patients' rights are respected, and clearly took their responsibilities as decision-makers seriously. They recognised the decisions they make are an exercise of legal power rather than a purely clinical decision and are not to be taken lightly.

It is perhaps reflective of clinicians' awareness of human rights and the legal limits of their powers that they are respectful of the role of lawyers in this field. For instance, notwithstanding their lack of mandate, Richard Charlton felt that on the whole there was acceptance of the role of lawyers at hospitals. Similarly, John O'Donnell felt that psychiatrists are really respecting of lawyers' roles and are appreciative of good lawyers, 'even though we challenge them'.

When I asked Tam Gill if she thought clinicians genuinely consider human rights when making decisions under the MHA, she seemed somewhat puzzled and replied that 'they have to' – the implication being that because the law required it then they necessarily did so. In my experience, the requirement to do so in no way indicates whether it is actually done in practice. Tam clarified that she believes that psychiatrists do in fact do this and that human rights considerations, such as the principle of least restriction, have moved beyond lip service and are embedded in clinical practice. She also felt that failures to comply with these obligations would be picked up in service accreditations and evaluations. She attributes the stronger human rights culture to the *Human Rights Act* having been in place for 15 years, the use and credible threat of enforcement mechanisms and consequences for non-compliance (including judicial review and breach actions under the *Human Rights Act*), and the tight regulation and oversight applied (these factors are discussed further below).

John O'Donnell also agreed that clinicians are very ethical and that human rights have been absorbed into their decision-making practice. He believes there is a culture of human rights compliance. Similarly, Professor Geneva Richardson felt that doctors today approach decision-making consciously with an awareness of the importance of their role.

Richard Charlton was a bit more circumspect, noting there was ‘enormous variation’ in administrative decision-making by doctors. However, he said that there has been a gradual improvement over time and a growth in awareness of human rights considerations. He felt this has resulted from the strict regulation of the responsible clinician role and his/her detaining functions, the *Human Rights Act*, the Code of Practice (see below) and doctors being conscious of the willingness of lawyers to pursue judicial review actions against their decisions.

In contrast, from an academic/researcher perspective, Dr Lucy Series was far less positive about the human rights compliance of general clinical practice:

There are still – especially in healthcare – many prevailing disablist and paternalistic attitudes, which results in people not being treated with respect and not being properly supported to make decisions about their own lives.

John O'Donnell and Peter Edwards noted that many psychiatrists and psychiatric registrars have extra qualifications including law degrees, in particular those working in forensic facilities, and that they have a ‘love of learning’. Professor Geneva Richardson said that having psychiatrists interested in studying and discussing the law has helped champion it within their hospitals and has influenced the approach of the Royal College of Psychiatrists (see below).

MHA administrator Sheena Ebsworth said that the hospital and staff are motivated to comply with the law for various reasons, including concerns about reputation, being sued, losing money (which takes away from patient care) and bad (clinical) outcomes for patients. For instance, she identified that if a report is done late and the patient’s lawyer has to seek an adjournment in order to properly prepare the case, and then the patient is released at the adjourned hearing, action may be taken against the service for breaching the patient’s rights because the patient should not have had to be detained pending the adjourned hearing. She was confident that non-compliance would be picked up through CQC reviews (see below) and saw litigation as a likely outcome of any failings. She struck me as very genuine and committed to this role.

While in England, I signed up to the Mental Health Law Online discussion forum.⁴⁰⁹ I have been very surprised that, every day, practising psychiatrists and other clinicians pose questions about what decisions they can or should make in a particular scenario they are dealing with and how they should apply the law, prompting an email dialogue with other clinicians, academics and lawyers in the field. These very conscious, reflective practitioners may be in a minority but it struck me as quite exceptional that they are seeking to engage in dialogue with external practitioners and lawyers on these questions, particularly as each hospital employs a MHA administrator, separate to any in-house counsel they may have, to ensure their compliance with the law (see below).

Non-lawyer factors shaping statutory and human rights compliance by mental health services in England

Key among the non-lawyer factors influencing compliance by English clinicians and mental health services with their statutory and human rights obligations are factors relating to practice standards and monitoring for quality and compliance. Although these factors exist or operate independently of lawyers, I have included them because they provide some insight into how a rights-compliant culture can be built, which is useful to consider against the Victorian context.

Clear statutory roles and responsibilities

The prescriptive regulations and training and accreditation requirements for people exercising administrative powers under the MHA were identified as having a positive impact on the protection of patient rights.⁴¹⁰

For example, admission for compulsory treatment under the MHA requires an application accompanied by two medical recommendations, at least one of which must ‘be given by a practitioner approved for the purposes of this section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder’.⁴¹¹ A registered medical practitioner who is an ‘approved clinician’⁴¹² is treated as meeting this requirement.

⁴⁰⁹ See <www.mentalhealthlaw.co.uk>.

⁴¹⁰ Richard Charlton, Geneva Richardson.

⁴¹¹ *Mental Health Act 1983* (UK) s 12(2).

⁴¹² An ‘approved clinician’ is ‘a person approved by the appropriate national authority to act as an Approved Clinician for the purposes of the Mental Health Act 1983’: *ibid* s 145(1).

In order for a registered medical practitioner to be approved as an 'approved clinician', they must demonstrate that they:

- Have attended a two-day initial training course for approved clinicians; and
- 'Possess the necessary competencies outlined in Schedule 2 of the Approved Clinician Directions and associated guidance, *Mental Health Act 2007: New Roles*,⁴¹³ which include: understanding the role of the approved clinician and responsible clinician; legal and policy framework; assessment; treatment; care planning; leadership and multi-disciplinary team working; equality and cultural diversity, and communication.⁴¹⁴

Unless they are already accredited on the Specialist Register (in which case they only need to submit appropriate references, a curriculum vitae demonstrating relevant experience and evidence that they are up to date with their continuing professional development requirements), they will also need to submit a portfolio to demonstrate that they meet those competencies. The portfolio must also include:

- A summary of their experience as relevant to the role of approved clinician;
- Two anonymised case commentaries relating to their involvement in the care of a detained patient, which must demonstrate awareness, understanding and reflection on key areas of approved clinician competence and the guiding principles of the Code of Practice;
- At least two relevant, anonymised, statutory reports which they have prepared;
- Two testimonies from suitably qualified professionals in a senior role who can validate their aptitude for the approved clinician role; and
- A 360 degree appraisal or equivalent that must include their immediate line manager/supervisor and multi-disciplinary team colleagues.⁴¹⁵

Approval as an approved clinician is valid for five years, at which time re-approval must be sought. The statutory requirements for re-approval are the same as those for approval, apart from the requirement to attend an initial training course.⁴¹⁶

In order to be a 'responsible clinician', even further training is required.⁴¹⁷

MHA administrators

While the role is not compulsory, most NHS Trusts employ one or more MHA administrators. They are responsible for ensuring that the Trust complies with the MHA and all relevant regulations, including the Code of Practice (see below) and human rights obligations. In practical terms, they:

- Train staff (there is mandatory initial and refresher training);
- Conduct audits (for example, on the quality of MHT reports) and produce audit reports;
- Check that records are complete (for example, that the file notes about the provision of rights information are detailed enough); and
- Chase compliance with statutory deadlines.⁴¹⁸

There is also a national network for MHA administrators, which provides a forum for them to discuss issues.

Sheena Ebsworth is the MHA administrator for Broadmoor Hospital and has worked there for 23 years. When she first started as the 'Mental Health Act and records manager', the records component of her role was much larger but that has completely reversed. She now has 4.5 FTE staff working under her solely on MHA compliance for the 200 patients at the hospital. MHA administrators are not in-house lawyers – in fact they are not lawyers – but most have specialist training such as a masters or diploma in mental health law.⁴¹⁹

⁴¹³

Available at <http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106654.pdf>.

⁴¹⁴

Royal College of Psychiatrists National Reference Group, *Applying for Approved Clinician approval* (2010) 2-3.

⁴¹⁵

Ibid 3-4.

⁴¹⁶

Ibid 5.

⁴¹⁷

Samrat Sengupta.

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Sheena Ebsworth.

⁴¹⁹

Sheena noted that not all mental health trusts require their MHA administrators to have mental health law qualifications.

Sheena said that staff are 'not at all' resentful of her team's role in ensuring compliance. Instead, they are appreciative because 'we help avoid them getting into trouble externally'. The regard in which she is held by clinical staff at her hospital was evident from consultant psychiatrist Dr Callum Ross's description of her when he arranged for me to meet her: she is 'worth more than her weight in the very best quality of diamond'.

Vesting ultimate responsibility for compliance in a particular role or individual, who is dedicated to that work rather than overburdened with competing commitments, means there is clearer accountability and no shifting of blame and responsibility.

Code of Practice

Section 118 of the MHA requires the Secretary of State to 'prepare, and from time to time revise, a code of practice' to guide approved clinicians, managers and staff of hospitals (including independent hospitals and care homes), AMHPs, registered medical practitioners and other professionals about the admission to hospital and psychiatric treatment of patients. The Department of Health states that the Code of Practice 'shows professionals how to carry out their roles and responsibilities under the [MHA], to ensure that all patients receive high-quality and safe care'.⁴²⁰

A significantly revised version of the Code of Practice came into force on 1 April 2015.⁴²¹ It is firmly grounded in a human rights framework, with the first 12 (of 40) chapters focusing on human rights and related principles:

- The first part (chapters 1-3) contains the '[u]nderlying principles for care, treatment and support under the [MHA] and good practice which advances equality and protects human rights', including the principles of empowerment, participation, least restrictive options, maximising independence, respect and dignity.
- The second part (chapters 4-12) explains '[i]ssues of importance when empowering patients in relation to their care and treatment, rights and autonomy, and ensuring they are treated with dignity and respect'.⁴²²

At 457 pages, the Code of Practice is incredibly detailed. It moves well beyond theory into detailed practice standards about a wide range of matters, including practices that particularly limit human rights, such as blanket restrictions and the use of restrictive interventions, particularly seclusion and long-term segregation.

People with roles and functions under the MHA are required to 'have regard to' the Code of Practice when performing those roles and functions.⁴²³ However, the House of Lords went further, stating in strong terms that the Code should be followed unless there are cogent and convincing reasons not to do so:

[Those to whom the Code is addressed] must give cogent reasons if in any respect they decide not to follow it. These reasons must be spelled out clearly, logically and convincingly. I would emphatically reject any suggestion that they have a discretion to depart from the Code as they see fit. Parliament by enacting section 118(1) has made it clear that it expects that the persons to whom the Code is addressed will follow it, unless they can demonstrate that they have a cogent reasons for not doing so. This expectation extends to the Code as a whole, from its statement of the guiding principles to all the detail that it gives with regard to admission and to treatment and care in hospital, except for those parts of it which specify forms of medical treatment requiring consent falling within section 118(2) where the treatment may not be given at all unless the conditions which it sets out are satisfied.⁴²⁴

The Code of Practice was identified as being influential in practice by many people I spoke with. For example, MHA administrator Sheena Ebsworth identified that the Safety and Security Directions (a statutory instrument which has blanket application at all high secure services such as Broadmoor Hospital) was incompatible to some extent with the revised Code of Practice when it was introduced. Accordingly, a workgroup was established at Broadmoor to go through the Code 'with a fine-toothed comb' to see what they can and cannot comply with and how they can maximise compliance with the Code. However, the CQC found that, while almost all staff had access to the Code, only half of the 58 wards visited in September and October 2015 had provided staff with training on the revised Code, which it described as 'unacceptable'.⁴²⁵

⁴²⁰ Department of Health (UK), 'News story: New Mental Health Act code of practice' (January 2015) <<https://www.gov.uk/government/news/new-mental-health-act-code-of-practice>>.

⁴²¹ Department of Health (UK), *Code of Practice*, above n 95.

⁴²² Ibid 4.

⁴²³ *Mental Health Act 1983* (UK) s 2D.

⁴²⁴ *R (Munjaz) v Mersey Care NHS Trust* [2005] UKHL 58, [69] per Lord Hope of Craighead.

⁴²⁵ CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 30.

... she is 'worth more than her weight in the very best quality of diamond'.

– English psychiatrist Dr Callum Ross, on the value of the MHA administrator

Lawyers use the Code of Practice as an objective reference to hold clinicians and services to account both during formal advocacy in front of the MHT and also in direct advocacy to administrative decision-makers. The MHT itself also encourages compliance with the Code of Practice. During an MHT hearing I observed, when a social worker was quizzed about discharge plans and what the local authority worker was planning for that patient, the social worker said that there were currently no discharge plans. The specialist lay member immediately jumped in to say that the Code of Practice requires discharge planning to commence at the time of admission, and again asked what is being done. In response, the social worker said he would immediately convene a planning meeting.

Royal College of Psychiatrists

In the absence of a statutory Chief Psychiatrist role (as Victoria has), the Royal College of Psychiatrists plays an important role in setting standards, training and monitoring compliance in a way that was identified as improving human rights compliance.⁴²⁶

The College Centre for Quality Improvement ('CCQI') 'aims to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide'.⁴²⁷ They do this by collecting information from patients, carers and staff about standards of care using national clinical audits, surveys and peer-review visits. In addition, the CCQI undertakes a lot of project work:

The CCQI's projects work to audit or review services against established guidelines and standards with the aim of supporting services to improve the quality of care they offer. Our quality and accreditation projects... cover a number of different types of services and work with them to improve standards through a process of regular peer and self review. Some projects also provide accreditation.⁴²⁸

There is significant buy-in for this work: more than 90% of mental health services in the UK participate in the work of the CCQI.⁴²⁹

What is also important about the Royal College of Psychiatrists' work is its inclusion of service users in setting standards and monitoring compliance (see 'Service user involvement in quality assurance' below).

The Care Quality Commission

The CQC is the independent regulator of health and adult social care services in England:

Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and we encourage care services to improve. Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.⁴³⁰

The CQC also has a particular responsibility to protect the rights and interests of people who are detained under the MHA:

Our [MHA] Commissioners make sure that the powers under the [MHA] are used properly. They check that people are being lawfully detained and are well cared for. The commissioners visit patients detained in hospital and meet them in private to find out about their experience of care. They also meet patients who are on [CTOs].⁴³¹

⁴²⁶ Richard Charlton; Geneva Richardson.

⁴²⁷ Royal College of Psychiatrists, 'College Centre for Quality Improvement' <<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx>>.

⁴²⁸ Royal College of Psychiatrists, 'CCQI National Clinical Audits, Service Quality and Accreditation Projects' <<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprjects.aspx>>.

⁴²⁹ Royal College of Psychiatrists, 'College Centre for Quality Improvement', above n 427.

⁴³⁰ CQC, *About us: what we do and how we do it* (undated) 2.

⁴³¹ Ibid 4.

'If we're not going to listen to what patients are saying, we're wasting our time talking about quality.'

– CQC national professional advisor in forensic mental health Dr Paul Gilluley

There have been changes to the way the CQC performs its functions – and consequently changes in its efficacy – over time. Dr Lucy Series said that back in 2007, a 'risk responsive' approach to regulation was adopted, whereby the frequency and depth of regulation was determined in response to issues raised, rather than conducted regularly for all facilities (which had been the previous, more costly, approach). Furthermore, while regulation had previously been carried out by specialist teams, the CQC moved to generalist teams covering all types of facilities. However, following some scandals in 2009, it moved back towards more specialist teams of assessors.

The CQC is not without its critics, and its failings were publicly exposed by the Winterbourne View scandal in 2011.⁴³² The CQC reports it has taken a number of steps since then to reduce the chances of such failings in future, including the recruitment of an additional 229 inspectors.⁴³³

Notwithstanding its problems, MHA administrator Sheena Ebsworth saw CQC monitoring as something to be taken very seriously by a service. As well as formal reviews, the CQC can send people in at any time unannounced. In fact, 95% of the 1292 monitoring visits completed by the CQC in 2014-2015 were unannounced.⁴³⁴ Sheena described their reviews as 'extremely involved' – 'teams of people descend' on the hospital, including clinical, legal and patient experts – and said they produce very detailed reports. Some of the key matters inspected by CQC investigators are:

- Quality of documentation, record-keeping and the safe storage of documents;
- Staff training including induction, knowledge of internal policy and procedure and external regulations;
- Staff knowledge of their patient group and familiarity with their individual records;
- Staff stability and dependence on temporary staff;
- Effectiveness of incident reporting;
- Medicines management; and
- Physical health care of patients.⁴³⁵

Like the Royal College of Psychiatrists, the CQC also actively involves service users in fulfilling its functions, including around 500 'experts by experience' (people who have experience of using care services) who take part in monitoring inspections⁴³⁶ (see below).

Service user involvement in quality assurance and other initiatives

The thing that interested and impressed me the most about the IAFMHS conference in Manchester was the strong emphasis on – and participation of – service users. The UK appears to be very advanced compared to many other jurisdictions in including service users and their views in quality assurance and service evaluation. It was not always this way: Dr Paul Gilluley said that, twenty years ago, service user involvement in forensic services was never thought about, and it was considered a risk to the service to involve them. Now, he says, 'If we're not going to listen to what patients are saying, we're wasting our time talking about quality'.⁴³⁷ As Mick Burns, an NHS mental health commissioner, said, 'Staff thought they were doing well with patient-centred care and involvement until they started talking to service users'.⁴³⁸ The shift towards service user involvement has been driven over the last few decades by the evolution of rights and safeguards, decrease in medical paternalism, emerging evidence around the value of patient self-medicating and self-monitoring and the identified cost of not involving patients.⁴³⁹

There were a number of presentations at the conference about how service users are being included in practice and how their feedback is being utilised to inform the indicators used for peer review and quality assurance in order to lift standards in areas that matter.

⁴³² The CQC failed to uncover or respond to whistleblower information that physical and psychological abuse was being perpetrated on people with intellectual disabilities and autism at this private care home – see reports at South Gloucestershire Safeguarding Adults Board, 'Winterbourne View' <<http://sites.southglos.gov.uk/safeguarding/adults/i-am-a-carerrelative/winterbourne-view/>>.

⁴³³ CQC, 'Our action in response to Winterbourne View' <<http://www.cqc.org.uk/content/our-action-winterbourne-view>>.

⁴³⁴ CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 18.

⁴³⁵ Andrew Parsons, 'The role of the CQC in improving operational and clinical safety' in *Partnerships in Care, Sharing Best Practice Resource Book* (2014) 32.

⁴³⁶ CQC, 'Involving people who use services' <<http://www.cqc.org.uk/content/involving-people-who-use-services#inspections>>.

⁴³⁷ 'Patient involvement in service governance and quality assurance' (presentation at the IAFMH conference, Manchester, June 2015).

⁴³⁸ 'Regional and national recovery initiatives in the UK' (presentation at the IAFMH conference, Manchester, June 2015).

⁴³⁹ Haque, above n 437.

Dr Quazi Haque, the executive director of Partnerships in Care, noted that traditionally there has been imprecise and ‘sloppy language’ in this domain – terms like ‘patient involvement’, ‘participation’, ‘engagement’ and ‘shared decision-making’ – but what they mean in practice has not been well articulated, which consequently impacts on them being measured.⁴⁴⁰ Partnerships in Care’s Ward Quality Matters initiative sought to bring more specificity and practical meaning to these concepts:

In 2014, all Partnerships in Care forensic hospitals in England, Scotland and Wales introduced ward-based monthly information accounts to assist clinicians and managers with monitoring and managing a comprehensive range of areas of care related to quality and safety. The ‘Ward Quality Matters’ initiative enabled patients to work in partnership with services to share key performance information and jointly implement local quality improvement plans based on the information set.⁴⁴¹

Dr Haque’s research highlighted a link between patient participation in quality monitoring and improvements in care outcomes. He concluded that ‘patient participation in quality monitoring is an intervention that requires further evaluation but may be as important as many drug treatments and therapies in determining service and individual patient outcomes’, which is a striking conclusion.

While visiting a hospital, I picked up a number of Partnerships in Care reports that were publicly available, including *Evidence-based care 2013/14*, which incorporates the results of patient surveys in the organisation’s self-evaluation, and *Sharing Best Practice Resource Book 2014*, which describes further ways in which service users’ opinions are feeding into practice.

Dr Paul Gilluley, who is the national professional advisor in forensic mental health at the CQC, also presented at the IAFMHS conference. He explained the important and expanding role played by service users in monitoring and improving the quality of psychiatrists and their practices:

The Quality Network for Forensic Mental Health Services at the Royal College of Psychiatrists was launched in 2006 and initially appointed two patient experts to sit on the Advisory Group. Since this time the role of patient expert involvement within the Network has developed, and includes: participation in Advisory Group Meetings, conducting patient expert-to-patient telephone conferences at self-review stage of the review, attending review visits as part of peer-review teams, regular contributions to the newsletter and presenting at the Annual Forum on the work of patient experts over the previous year.

As at 2013, there were 12 patient experts with expanded roles, including in standards development. When Paul first reported an intention to have service users as part of the peer review group rather than just as advisors to the advisory group, ‘the outcry from providers was volatile to say the least’, but now services find it ‘extremely useful’. After all, patients ‘are on the wards 24/7 and know better than any staff member what’s going on’. Patient experts are also better able to gain information from patients during peer review, which improves the validity of the review.

In addition, there are numerous significant, recovery-focused initiatives happening across the UK. For instance, a network of nine regional Recovery and Outcomes Groups was established to bring together commissioners, managers, practitioner staff and, crucially, service users to reflect upon local progress and share best practice. They are facilitated by Ian Callaghan, himself an ex-user of secure services. A steering group meets to discuss issues arising from the regional meetings. Their status and impact is significant. For example:

- Representatives sit on the Clinical Reference Group advising NHS England;
- They have input into Commissioning for Quality and Innovation (**‘CQUIN’**; see below) payment frameworks and a role in helping to embed CQUIN frameworks in services; and
- They participate as patient experts in peer reviews conducted by the Quality Network of the Royal College of Psychiatrists.

⁴⁴⁰
Ibid.

⁴⁴¹
Abstract for Quazi Haque, ‘Patient involvement in service governance and quality assurance’ (presentation at the IAFMH conference, Manchester, June 2015).

The CQUIN payment framework 'enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals'.⁴⁴² As just one example, in April 2014, Partnerships in Care developed a CQUIN scheme called the 'Identifying Risk Programme' to collaboratively involve patients in their own risk assessment. Moving away from the traditional medical model to a shared decision-making model, it provides patients with an understanding of their risk of violence and encourages personal responsibility to adjust and change their behaviour in the future. Partnerships in Care concluded that the introduction of this program, which is being phased in over two years, has enhanced discharge planning.⁴⁴³

On the ground, Sheena Ebsworth said that, at Broadmoor Hospital, they are trying to get patients more involved in their treatment and recovery planning in other ways, for instance, by getting them to chair their own CPA meetings.⁴⁴⁴

Each year, national service user awards are made to celebrate of the large number of service user-led initiatives in inpatient services in England, to recognise the achievements of individuals and their initiatives and to encourage even more service user-led initiatives.⁴⁴⁵

Some ideas from Canada (via the IAFMHS conference in Manchester)

Shared ownership of clinical file and recovery

Dr Lisa Marshall is a psychologist in the Forensic Rehabilitation Unit at Ontario Shores Centre for Mental Health Services ('Ontario Shores'), a 339 bed psychiatric hospital in Canada. She is also an assistant professor in the Department of Psychiatry at the University of Toronto. At the IAFMHS conference, she spoke about her research and practices to enhance recovery in forensic settings through engagement, collaboration and innovation.⁴⁴⁶ She explained that patient engagement and collaboration is very important because a sense of powerlessness and external locus of control hinders recovery. Also, patients typically have a well-developed idea of what recovery means for them which may be very different from the clinical perspective. As a patient in her research stated, 'Most nurses do care you recover, it's just that they're pretty simplistic about what recovery means'.

One practical strategy she described to give patients greater ownership of their recovery was to give them greater control of their file. Patients are assessed and treated according to what is written down in the file. Typically, however, staff have full control over this; they are necessarily selective in what they write and generally write down their subjective interpretations rather than what was actually said or done. To improve patient control, portals have been installed at Ontario Shores where patients can log on to access their notes at any time. In the future, they will also be able to annotate and add things into their file through these portals.

Ethicists as decision-making guides

Rosanna Macri is a bioethicist employed by Ontario Shores.⁴⁴⁷ Part of her role is to assist staff to 'live' the organisation's mission, vision and values when making decisions 'from bedside to boardroom'. This includes providing direct decision-making support to clinicians considering how to exercise their powers in respect of individual cases. She receives around ten requests from staff for direct consultations each month, and the role is growing. She feels that on the whole the hospital is 'incredibly supportive' of her role and the assistance she provides. Ontario Shores has also engaged the Ontario Human Rights Commission to assist in ensuring that human rights laws are embedded in their approach. A three-year Charter agreement has been signed by both organisations, solidifying their partnership and engaging the Commission to sit on several of their working groups.

While such a role has the potential to very directly shape a human rights-respecting approach by administrative decision-makers, Dr Lucy Series noted that bioethics stems from and is strongly influenced by the medical model. She therefore thought it would be better to have a human rights-based person and/or a consumer talking through decisions with clinicians to provide a more independent sounding board.

⁴⁴² NHS Institute for Innovation and Improvement, 'Commissioning for Quality and Innovation payment framework' <http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html>.

⁴⁴³ 'Patient involvement in risk assessment – a highly measurable new intervention' in Partnerships in Care, above n 435, 36.

⁴⁴⁴ For an explanation of CPA meetings, see footnote 380 above.

⁴⁴⁵ See National Service User Awards website <<http://www.nsua.org/>>.

⁴⁴⁶ Lisa Marshall, 'Enhancing recovery in a forensic setting through engagement, collaboration and innovation' (presentation at the IAFMHS conference, Manchester, June 2015).

⁴⁴⁷ I spoke to Rosanna by skype on 23 July 2015, after learning about her role through talking with Dr Lisa Marshall at the IAFMHS conference.

‘Most nurses do care you recover, it’s just that they’re pretty simplistic about what recovery means’.

– Patient in Dr Lisa Marshall’s research

In response, Rosanna explained that the foundations of bioethics are medicine, the law, philosophy and cultural/spiritual beliefs. Therefore, although bioethics is influenced by the medical model, she does not think that it outweighs the other pillars of consideration. Rosanna recognised that human rights and consumer advocates each have very unique and valuable perspectives which they could lend to a case, and that it would be ‘ideal’ to have all stakeholders at the table (ie human rights and consumer advocates along with the healthcare team and potentially family or friend supports). However, in the healthcare environment, that is not always possible. During the course of her role, she has learnt that ‘we need to learn from each other in order to develop the best, or at least the least harmful, suggestions with clients’, and that this must be done in collaboration and not isolation with adequate training on both ends.

Reflections

It is clearly not a lawyer’s role to set standards for clinical practice. However, ensuring that the standards and indicators of quality and performance against which mental health services are evaluated include human rights considerations and service user involvement will significantly help to promote the rights-protecting goals which lawyers are working towards. Prompting and supporting evaluation and quality assurance work within mental health services is also important. As the primary legal service practising in this field, MHDL needs to have an understanding of what evaluation and quality assurance work is already happening and learn how we can feed our practice experience into this to ensure that standards and indicators are appropriately comprehensive.

In Victoria, the Secretary to the Department of Health and Human Services is empowered to make a Code of Practice pursuant to s 367(1) of the *Mental Health Act 2014*, for the purpose of ‘provid[ing] practical guidance to any person or body exercising powers or performing functions and duties under this Act to promote best practice’.⁴⁴⁸ In developing a Code of Practice, the Secretary may consult with ‘any consumer advocacy group’ and ‘any other person the Secretary considers should be consulted’.⁴⁴⁹ However, a Code of Practice has not yet been developed. Given how useful the Code of Practice has been in England for setting standards, advocacy and accountability, it would be beneficial for Victoria to develop one as soon as possible.

Victoria is fortunate to have a statutory position of ‘Chief Psychiatrist’, whose primary functions are to develop and assist mental health services to comply with standards, guidelines and practice directions.⁴⁵⁰ However, only a very small number of Chief Psychiatrist practice directions have been updated since the commencement of the new MHA in July 2014, and no new directions have been issued to deal with the novel challenges which the Act brings for clinicians and mental health services more broadly (including how to assess ‘incapacity’ of a patient and how to make a (lawful) compulsory treatment decision).⁴⁵¹

⁴⁴⁸ *Mental Health Act 2014* (Vic) s 366(1).

⁴⁴⁹ *Ibid* s 367(2)(f), (g).

⁴⁵⁰ *Ibid* s 121(1)(a), (b).

⁴⁵¹ The Department of Health’s *Mental Health Act 2014 Handbook*, ‘designed to help clinicians access the information they need to practice in accordance with the new [Act]’, does little more than set out the express requirements of the Act – see <<https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook>>.

... it is necessary to highlight the risks and 'costs' of unlawful or unfair decisions.

Conclusion

In the jurisdictions I visited, lawyers influenced administrative decision-makers in different ways and to varying degrees of success. These differences were primarily influenced by the lawyers' mandate (or lack thereof) and the particular legal frameworks and legal service models.

One thing emphasised in both jurisdictions was that, to improve compliance and lift standards, it is necessary to highlight the risks and 'costs' of unlawful or unfair decisions. Getting the other party or decision-maker to understand and properly weigh the risks associated with the position you are advocating against is important. John Brayley, the Public Advocate of South Australia, noted that, in a mental health context, risk is usually just conceptualised as risk of deterioration in mental state or harm to the patient or those around them. However, there is also risk in compelling treatment, as compulsory treatment can be a traumatic experience and is therefore in and of itself a risk to the patient and their likelihood of future engagement with the service and/or treatment. In the litigious US context, Michael Perlin said that conservative, risk-avoidant thinking in services is usually driven by fear of being sued as a result of a harm occurring from releasing a person from commitment. He believes it is essential for services to understand that they can also be sued for the harm that occurs from *failing* to release a person and/or respect their rights. He emphasised that lawyers need to be willing and able to take such actions in order for this to be a credible risk or 'cost' that services will then factor into their decision-making.

There is evidently a culture of compliance, and an embedded understanding of the *importance* of compliance, with statutory requirements and human rights considerations in England, which is constantly reinforced by activities of lawyers and other factors. Clinicians are trained and expected to be very conscious of the fact that they are exercising a legal power (albeit it one based in part on clinical judgment), and for the most part are genuinely conscious of the human rights dimensions to the decisions they make. They are also conscious that their decisions are subject to review and oversight, and this consciousness is maintained by the readiness of lawyers to mount challenges.

In September 2015, the Victorian Attorney-General tabled in Parliament the eight-year statutory review of the Charter by Michael Brett Young. It states:

A strong human rights culture facilitates better government decision making. Having the law is not enough to achieve human rights protection. Victoria also needs a culture that makes human rights real in everyday interactions with government. The best human rights outcomes are achieved if people's rights are considered in the everyday business of government and its interactions with the community. For this reason, *I recommend the Victorian Government prioritise its focus on human rights at this front-end.*

There is no one-size fits all approach to building a human rights culture, but three important influences must be addressed: senior leadership and vision; operational capacity; and external input and oversight. An effective approach to building a human rights culture will draw on each of these elements (emphasis added).⁴⁵²

How can Victorian legal services play their part in supporting a human rights culture within mental health facilities? Due to its similar legal framework and the evident impact which lawyers have had, England provides a good model for Victoria to look to. Furthermore, notwithstanding its lack of formal mandate, MHDL is also uniquely positioned to emulate the MHLS' function of shaping conditions and culture within services through its regular, on-site presence, interactions with staff and scrutinising practices.

⁴⁵²
Brett Young, above n 397, 19.

Improved understanding, cooperation and – where appropriate – collaboration between legal services and mental health services can be very beneficial for all concerned. It is important to seek solutions to both practice and relationship issues as they arise rather than simply becoming oppositional. Regular, open dialogue is essential to help understand each other's role and motivations and to identify potential shared goals and opportunities for collaboration. Lawyers working in this field need to understand the operational nature of mental health services and acknowledge the challenges they face. They should also be proactive in suggesting positive solutions rather than simply being critical. In turn, mental health services should make efforts to understand the role that lawyers play and why that is important. Managers, clinicians and nursing staff should avoid seeing lawyers entering their service as meddlesome troublemakers but instead as a welcome resource that not only helps their patients but can assist them in fulfilling their own functions and obligations. Research suggests that adopting a human rights approach is also beneficial for mental health services themselves because it:

- Changes the culture from 'us and them' to a positive and constructive atmosphere of mutual respect between staff and patients;
- Increases work-related satisfaction among staff;
- Increases acceptance and satisfaction among patients about their care and treatment;
- Reduces staff anxiety and stress; and
- Reduces staff 'fear' of human rights, and increases their understanding of how to make choices and of the meaning and benefit of their own human rights.⁴⁵³

RECOMMENDATIONS AND IDEAS

- ▶ Develop training and protocols regarding particular matters which IMHA should look out for and refer to MHDL for legal advocacy.
- ▶ Take steps to increase MHDL's administrative law practice, including engaging with barristers/legal experts and establishing a VLA guideline for legal assistance for judicial review matters.
- ▶ Establish and/or strengthen relationships between MHDL and clinical directors and other key staff at mental health services to discuss issues arising in practice.
- ▶ Encourage the Secretary to the Department of Health and Human Services to consult on and develop as soon as possible a Code of Practice to provide best practice, practical guidance to people and bodies exercising powers or performing functions and duties under the MHA.
- ▶ Encourage the Chief Psychiatrist to develop practice directions or other guidelines to assist clinicians and others to correctly fulfil their new roles under the *Mental Health Act 2014*, especially regarding how to assess 'incapacity' of a patient and how to make a (lawful) compulsory treatment decision (including record-keeping requirements).
- ▶ Engage with statutory offices and organisations with oversight and regulatory functions, such as the Chief Psychiatrist, the Public Advocate, community visitors and the Mental Health Complaints Commissioner, to:
 - Learn more about each others' functions;
 - Develop protocols for passing on information about what MHDL observes in practice (to feed into both the development of standards and evaluation of particular services); and
 - Advocate for them to adopt evidenced-based and effective human rights monitoring tools.

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Jem Stevens, 'Changing Cultures in Closed Environments: What works?' in Bronwyn Naylor, Julie Debeljak and Anita Mackay (eds), *Human Rights in Closed Environments* (Federation Press, 2014) 228, 252, referencing Scottish Human Rights Commission, *Human Rights in a Health Care Setting: Making it Work. An Evaluation of a Human Rights-Based Approach at the State Hospital* (2009) 5-6.

3D. HOW INFORMALLY DETAINED PEOPLE WITH DISABILITIES OBTAIN LEGAL ASSISTANCE

How is access to legal assistance relevant to rights protection for informally detained people?

As noted in the introduction, people with disabilities may be informally detained in a range of closed environments in the absence of any clear legal authority; while they may be complying with or acquiescing to very high levels of supervision and restrictions on their liberty, they may not be giving full, free and informed consent because:

- They lack the mental capacity to give informed consent because of, for instance, significant cognitive deficits, acute symptoms of mental illness, medication side effects or some other factor; or
- They are only complying under pressure or duress because, for instance, they suspect or have been told that they would be put under a legal order and forced comply, or would face some other consequence, if they did not.

As with people who are formally detained, a lawyer cannot assist someone who is informally detained, or take any action to protect their rights, unless they are in contact with and receive instructions from that person.

Because of the informal nature of the restrictions, there is no external trigger such as a scheduled court or tribunal hearing to prompt the involvement of a lawyer who could provide them with independent advice. This means that the people themselves must generally take the initiative to contact a lawyer. However, while an informally detained person may be unhappy with their situation or wish to have greater freedoms, various factors may prevent them from proactively seeking legal assistance:

- They may be unaware of the legal dimension to their circumstances and the potential utility of a lawyer;
- They may be unaware of the availability of legal services;
- They may lack the resources and/or ability to independently seek help; and
- They may lack of faith in the legal system to help them, particularly if they have become institutionalised.

As explained in Part 3A above, there are clear statutory entitlements and established service mechanisms for people who are formally detained in New York and England to obtain legal assistance. However, these may not apply or be sufficient for people with disabilities who are in closed environments informally.

In conducting this part of the research, I explored:

- Whether and how people who are informally detained are able to access legal assistance; and
- Whether there are any indirect ways for lawyers to reach behind closed doors to assist in the protection of their rights.

Statutory protections and oversight of informal admissions: New York

The New York *Mental Hygiene Law* formally recognises both ‘informal’ patients and ‘voluntary’ patients. It provides a number of statutory protections to help ensure that any patient who does not freely consent to their admission or treatment is able to access legal advice, and also that some periodic legal oversight of their situation occurs:

- As soon as they are admitted, the hospital must inform the patient in writing of their legal status and rights, including their right to assistance from the MHLS.⁴⁵⁴
- The hospital is required to display notices around the hospital, ‘conspicuous and visible’ to all patients, explaining their rights, including the availability of the MHLS.⁴⁵⁵
- The hospital must re-inform each patient of these matters every 120 days.⁴⁵⁶

⁴⁵⁴
Mental Hygiene Law § 9.07(a).

⁴⁵⁵
Ibid § 9.07(b).

⁴⁵⁶
Ibid § 9.19.

- Whenever this is done, the hospital must obtain the written consent of the patient to continue their stay under that legal status and provide a copy of their consent to the MHLS.⁴⁵⁷
- Once a year, both the hospital director and the MHLS must review the 'suitability and willingness' of each voluntary or informal patient to remain on that status. If, at the annual review, the MHLS finds 'that there is any ground to doubt' the director's determination of the patient's suitability and willingness to remain in hospital, the MHLS must apply to the court for an order determining those questions.⁴⁵⁸

Similarly, under the *Mental Retardation And Developmental Disabilities Act*, a person may be admitted to a 'school'⁴⁵⁹ without a formal court order if they passively acquiesce to it, despite lacking the capacity to consent.⁴⁶⁰ The MHLS must be informed in writing whenever someone is admitted on this basis,⁴⁶¹ 'promptly review' the admission and continue to review their admission at least once a year.⁴⁶²

Reflections

The situation is very different in England and Victoria. *The Mental Health Act 1983* (UK) does specifically note that people can be admitted to and/or remain in hospital as an informal patient.⁴⁶³ However, unless the person is considered to lack capacity (see below), the law does not regulate the restrictions informally placed on them and there is no external oversight or scrutiny of what happens to them: 'These patients have none of the rights of [formally] detained patients to ensure that their detention is lawful'.⁴⁶⁴

In England, if a person is unhappy with or wants advice about their situation, it is up to them to proactively seek out the contact details for a lawyer and request assistance (as there is no requirement for the hospital to provide them with a statement of rights or contact details). Even if they do this, it is doubtful that a private lawyer would provide much, if any, assistance as their informal status means they do not fall within the scope of work covered by the legal aid contract for mental health work. As noted above, there is no other effective, accessible way to get legal advice over the phone in England.

Emma Norton said that Liberty (the National Council for Civil Liberties in the UK) is concerned about this issue and is currently looking to clarify through strategic litigation the rights of people who are technically voluntary inpatients but who may nevertheless be subject to coercion to stay and/or accept treatment.

Bringing formality to informal detention for people lacking capacity: England's DOLS scheme

As noted above, there is no recognition or oversight in England for people who have decided to acquiesce – however reluctantly – to being deprived of their liberty if they have the capacity to make that decision. But what if the person does not have the capacity to give informed consent to their restrictive circumstances?

The '**Bournewood gap**' refers to a gap in the law in which a person is deprived of their liberty in the absence of clear lawful authority because, although the person does not resist their situation, they are considered to lack the mental capacity to give informed consent to it.

The name derives from the English case of *R v Bournewood Community and Mental Health NHS Trust*,⁴⁶⁵ which concerned a profoundly autistic and non-verbal man, HL, who was being objectively detained and medicated in a locked hospital ward. Because he was compliant or not expressing objection to his circumstances, he had not been formally detained under the MHA. In the absence of HL's ability to provide informed consent to the restrictions, the hospital relied on the common law doctrine of necessity to authorise their restrictive actions.

While the House of Lords concluded that HL was not being detained in breach of the common law, in 2004 the ECtHR concluded that this arrangement breached article 5(1) and (4) of the ECHR because of the lack of procedural safeguards and lack of access to a court.⁴⁶⁶

In 2009, in response to the ECtHR's decision, England introduced a new statutory scheme – the 'deprivation of liberty safeguards' ('**DOLS**') – into the MCA to close the Bournewood gap.

⁴⁵⁷

Ibid.

⁴⁵⁸

Ibid § 9.25(a).

⁴⁵⁹

'School' 'means the in-patient service of a developmental center or other residential facility for the mentally retarded and developmentally disabled under the jurisdiction of the office of mental retardation and developmental disabilities or a facility for the residential care, treatment, training, or education of the mentally retarded and developmentally disabled which has been issued an operating certificate by the commissioner of mental retardation and developmental disabilities': ibid § 1.03(11).

⁴⁶⁰

Such an admission may occur if the person is 'in need of care and treatment', does not object to being retained there and is 'so profoundly or severely mentally retarded that he [or she] does not have sufficient understanding to make him suitable for admission as a voluntary resident': ibid § 15.25(a).

⁴⁶¹

Ibid § 15.25(d).

⁴⁶²

Ibid.

⁴⁶³

Mental Health Act 1983 (UK) s13(1).

⁴⁶⁴

Rosanne Macgregor-Morris, Jane Ewbank and Luke Birmingham, 'Potential impact of the Human Rights Act on psychiatric practice: the best of British values?' (2001) 322 *British Medical Journal* 848, 849.

⁴⁶⁵

R v Bournewood Community and Mental Health NHS Trust Ex p. L [1998] UKHL 24.

⁴⁶⁶

HL v UK (2004) Eur Court HR 471.

The DOLS scheme provides some regulation and oversight of what would otherwise be informal detention of people who lack the capacity to make such a decision. DOLS requires that hospitals and care homes apply to their local authority for authorisation of the deprivation of liberty where:

- The person is objectively being deprived of their liberty in the hospital or care home;
- They are not resisting the restrictions; but
- They lack the mental capacity to consent to them.

The DOLS scheme is described further in Appendix 6.

This obligation on hospitals and care homes to create a record and seek authorisation for their actions provides some objective transparency to what would otherwise be hidden arrangements, which should facilitate rights protection. Unfortunately, however, every person I spoke with said that there are significant problems with the operation of the scheme.

Dr Lucy Series noted that the DOLS procedural safeguards are very weak, with opportunities for independent advocacy and scrutiny also quite limited: 'if you're lucky you might get an advocate, and in some cases it might end up in court'. As a result, many people who are subject to a DOLS application do not receive legal advice or assistance at all. The proper scope of involvement of the person who is the subject of a DOLS application is something which the Court of Protection is still struggling to determine. After a series of cases on this point, in September 2015 the Court of Protection decided that they need not always be joined as a party,⁴⁶⁷ which may limit their voice being properly heard in the proceedings.

There are also issues with the method through which legal representation – if it is in fact available – is provided. Because people under DOLS are normally regarded as lacking litigation capacity and require a 'litigation friend',⁴⁶⁸ they are usually represented by a barrister, who is instructed by a solicitor, who in turn is instructed by the Official Solicitor (the Official Solicitor is the public body funded to provide litigation friend services as a last resort to people who are asserted to lack capacity).⁴⁶⁹ Alex Ruck Keene, a barrister and academic specialising in MCA matters, noted that the roles and duties when acting as a litigation friend are very confusing and hard to understand.⁴⁷⁰ Some people I spoke with expressed some concern about the way the Official Solicitor carried out his functions: he 'likes to run cases his own way', which puts a limit on the creativity and innovation the retained barrister can bring to the case.⁴⁷¹ He has also been known to withdraw appeals made by the person on the basis that they lack merit, notwithstanding the person's strong wishes.⁴⁷² In some cases, barristers find themselves in the odd position of having to tell the court that, although the person they represent wants a particular outcome, they are asking for a different outcome. Alex noted that the Official Solicitor is meant to be independent of government but, 'both practically and as a matter of perception, issues can and do arise given the fact that the office is funded by the Ministry of Justice'.

Furthermore, everyone I met told me that the DOLS system is overly complex and excessively bureaucratic. Veteran lawyer John O'Donnell described the scheme as a panicked response which was not well thought through. It involves very slow civil litigation, which has caused a backlog of cases in the Court of Protection. Lucy Series also noted that the Court of Protection is under-resourced and that its processes 'aren't really set up to facilitate proper participation by those who are subject to the court's jurisdiction'. In March 2014, a House of Lords Select Committee published a detailed report concluding that the DOLS system is 'not fit for purpose' and recommended that it be replaced.⁴⁷³

To make matters worse, in March 2014, a Supreme Court decision known as *Cheshire West* (see box below) significantly expanded the reach of DOLS by rendering irrelevant certain factors that had confined its scope in the past.

⁴⁶⁷ Re NRA [2015] EWCOP 59, [177].

⁴⁶⁸ Lucy Series. A litigation friend is a person appointed to conduct proceedings on behalf of a person asserted to lack capacity; they will provide instructions to the lawyer about how the case should proceed.

⁴⁶⁹ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 55.

⁴⁷⁰ He has written a 68 page guidance note, commissioned by the Department of Health, on the subject: *Acting as a litigation friend in the Court of Protection* (University of Manchester, 2014).

⁴⁷¹ (anonymous).

⁴⁷² See *TA v AA* [2013] EWCA Civ 1661, referred to in MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 55.

⁴⁷³ House of Lords Select Committee on the Mental Capacity Act 2005, *Mental Capacity Act 2005: post-legislative scrutiny*, Paper 139 (2014).

P v Cheshire West and Chester Council [2014] UKSC 19

In this case, the Supreme Court considered the situation of three adults without capacity to consent to their residence and care arrangements. The court had to determine whether they were being deprived of their liberty. It was not suggested that the arrangements were more restrictive than any of them required and none of them appeared dissatisfied with the arrangements, which were all held to be benevolent and in the persons' best interests.

However, because of the extreme 'vulnerability' of people in this situation, the Court held that decision-makers should err on the side of caution in deciding what constitutes a deprivation of liberty.

The court decided that the 'acid test' for deprivation of liberty is whether:

- The person is under continuous supervision and control;
- They are not free to leave; and
- Their care arrangements are the responsibility of the state.

It held that the following factors are *not* relevant to the question of whether they are deprived of their liberty:

- The person's compliance or lack of objection;
- The relative normality of the placement (whatever the comparison made); and
- The reason or purpose behind a particular placement.

The court also made clear that a deprivation of liberty could apply in a domestic setting, as well as in health or social care placements.

As a result, the system is now in chaos. There were 137,540 DOLS applications brought in the year following *Cheshire West*, a ten-fold rise over the previous year.⁴⁷⁴ The system cannot cope with this surge in demand: as at March 2015, 56,835 applications remained undetermined by local authorities, compared to 359 in the previous year.⁴⁷⁵ There are still potentially tens of thousands of people being detained in the UK without lawful authority and there is 'widespread non-compliance' with what the law strictly requires.⁴⁷⁶ Lucy Series summed up how DOLS is failing to protect the human rights recognised by the ECHR and CRPD as follows:

In terms of the ECHR, there are widespread violations of the right to liberty. We know that, because of [the *Cheshire West* decision,] local authorities are not able to process the vast numbers of applications for authorisations, so loads of people are detained with no legal authority. Even where people are formally deprived of their liberty, the frameworks to enable them to appeal are so weak... And then when cases do get to court, although there are some great judgments, the court process is so slow it's doubtful it constitutes a 'speedy' right of review... [T]here are major problems with the way people are represented in court which means that their own lawyers may refuse to challenge a detention if they think it's in the person's best interests, even if the person themselves is objecting. There is also a lack of clarity about what local authorities can do without a court order – can they, for example, remove somebody from their home or family against their will and cut off contact with their family and friends? These are major human rights concerns.

In terms of the CRPD, it'd be hard to be compliant with the CRPD whilst practising under the MCA, because the law itself is not compliant. But that notwithstanding, even the bits of the CRPD that could be complied with, such as supported decision making, in practice are not.

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Health and Social Care Information Centre, *Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual Report 2014-15* (2015) 5.

⁴⁷⁵

CQC, *Monitoring the Deprivation of Liberty Safeguards 2014/15* (2015) 5.

⁴⁷⁶

Alex Ruck Keene; also Lucy Series. See also CQC, *Monitoring the Deprivation of Liberty Safeguards 2014/15*, above n 475, which noted that 'a high number of people [are] likely being deprived of their liberty without the protection of external scrutiny – including the independent assessments, advocacy and representation that ensure people are only deprived of their liberty appropriately, and consequently that they receive care which meets their needs and is consistent as much as possible with their wishes': 13.

There is a strong feeling that DOLS is not necessarily targeting those who most need protection or achieving the intended benefits in practice. The following online post by a social worker at a community mental health service for older people captures the frustration felt by many frontline staff:⁴⁷⁷

If this was Trip Advisor, I could only give the MCA two stars (and it only gets this because of the five principles).⁴⁷⁸

I have just learnt that another day centre has closed but our DOLS dep[artment] has increased from three to 13 staff. I also know that my manager and several other managers have spent the best part of a week debating whether an elderly gentlemen who is prescribed an anti-psychotic, who is ok during the day but becomes distressed at night, should be detained under the MHA or the MCA. No one believes he should not be on the ward but the amount of debate as to which bit of paper to waive under his nose was unbelievable. How can the great minds spend five years writing the MCA and yet fail... to address the relationship between the two Acts?...

Since [DOLS] has come in, we have marched in more directions than the Grand Old Duke of York. When it was first implemented, it could not have been used for Bournewood, the very case that inspired the legislation...

Then there is the DOLS paperwork, the most bureaucratic, long-winded forms in the history of long-winded forms. How come you can do [an inpatient treatment order] on a couple of sides of A4 yet it needs a whole tree to keep a... person with dementia in a care home?

The DOLS chaos is also creating a very significant demand on clinical and justice resources in times of austerity. However, the fact that the DOLS system has got to a crisis point at least means that people are now talking about the issue; even though people do not see eye to eye on it,⁴⁷⁹ it has created dialogue across the sector and meaningful debates in Parliament.⁴⁸⁰ Lucy Series said the Essex Autonomy Project (EAP),⁴⁸¹ which does research into the philosophy behind the MCA, suggested that the government host roundtable discussions on the CRPD and MCA to inform the review of it. The roundtables – which were ‘heated and vigorous’⁴⁸² – led to an EAP report in September 2014 which concluded that the MCA was not fully compliant with the CRPD. The government’s response has not yet been published.⁴⁸³ However, on 7 July 2015, just after I left England, the Law Commission published its long-awaited consultation report on the MCA and DOLS, concluding that DOLS is ‘deeply flawed’ and provisionally proposing that it be replaced with a new system.⁴⁸⁴ It will publish a final report and draft Bill in 2016.

Reflections

The Bournewood gap – whereby people with disabilities are kept in conditions amounting to detention without their informed consent or any other clear lawful authority – still exists in Victoria.⁴⁸⁵ People in this situation remain hidden from view in places like nursing homes and group homes around the state, with no mechanism to trigger their access to independent legal advice.

The VLRC considered the Bournewood gap and informal restrictions on liberty in residential care, as well as the English DOLS scheme, in its report on guardianship laws in 2012. Ultimately, the VLRC did ‘not propos[e] any changes to these practices even though the existing informal arrangements clearly lack any legal foundation’.⁴⁸⁶ Its reasons for this were that the Bournewood gap issue has not yet been litigated in Victoria (despite acknowledging if it was litigated it may well produce the same result⁴⁸⁷), the Charter does not oblige the Victorian government to act to ensure rights are protected,⁴⁸⁸ and it did not want to create administrative burdens on services where informal arrangements ‘appear to operate reasonably well at the moment’.⁴⁸⁹ The VLRC concluded that DOLS was ‘not supportable’ as a solution⁴⁹⁰ but did suggest developing a ‘collaborative authorisation process’ (whereby the detaining service, a doctor and the person’s ‘health decision-maker’ agree), unless the person ‘consistently resists and opposes restrictions on their liberty’.⁴⁹¹ The government’s response to the VLRC’s recommendations, the Guardianship and Administration Bill 2014, did not include any legislative mechanism to close the Bournewood gap (and in any event lapsed without being passed).

⁴⁷⁷ Mental Health Law Online discussion board, 28 October 2015 (reproduced with the author’s permission; punctuation edited for readability).

⁴⁷⁸ The five principles contained in s 1 of the MCA are that: a person must be assumed to have capacity unless it is established otherwise; a person is not to be treated as unable to make a decision, unless all practicable steps to help him do so have been taken without success; a person is not to be treated as unable to make a decision merely because an unwise decision is made; an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and before the act is done, or the decision is made, care must be taken to avoid restricting the person’s rights and freedom of action.

⁴⁷⁹ Lucy Series.

⁴⁸⁰ Alex Ruck Keene.

⁴⁸¹ See Essex Autonomy Project, ‘MCA compliance with the UN CRPD’ <<http://autonomy.essex.ac.uk/mca-compliance-with-the-uncrpd>>.

⁴⁸² Wayne Martin, Sabine Michalowski, Timo Jütten and Matthew Burch, *Achieving CRPD compliance: Is the mental capacity act of England and Wales compatible with the UN Convention on the Rights of Persons with Disabilities? If not, what next?* An Essex Autonomy Project position paper (September 2014).

⁴⁸³ Lucy Series.

⁴⁸⁴ Law Commission, *Mental Capacity and Deprivation of Liberty: A Consultation Paper* (2015).

⁴⁸⁵ In very limited circumstances, VCAT can make a ‘supervised treatment order’ to authorise the detention of a person with an intellectual disability who poses a significant risk of serious harm to others for the purposes of compulsory treatment: *Disability Act 2006* (Vic) s 191.

⁴⁸⁶ VLRC, *Guardianship*, above n 8, 336.

⁴⁸⁷ *Ibid* 329, 336.

⁴⁸⁸ *Ibid*.

⁴⁸⁹ *Ibid* 336.

⁴⁹⁰ *Ibid* 337-8.

⁴⁹¹ *Ibid* 339.

‘... the amount of debate as to which bit of paper to waive under his nose was unbelievable.’

– Social worker at an English community mental health service, on the unclear interaction between the MHA and the MCA

Of course, not all people who are objectively detained in closed environments are unhappy with their circumstances or desirous of legal assistance. Furthermore, as Alex Ruck Keene noted, there are ‘multiple valid views’ about whether there is greater dignity and other benefits in permitting people to be informally admitted and treated – despite lacking the capacity to give informed consent or only acquiescing under duress – rather than requiring them to be subject to a formal legal authorisation to detain them.

New York’s system is quite appealing as it strikes a balance by ensuring transparency of legal status, readily accessible legal assistance and some periodic, independent oversight without formally depriving the person of their liberty. However, it is only effective because there is a designated and adequately resourced legal service to fulfil those functions, which we do not yet have in Victoria.

Indirect ways for lawyers to reach behind closed doors

Independent Mental Capacity Advocates: England

While private lawyers in England might have limited opportunities to get behind closed doors themselves, particularly in the absence of a request or instructions for assistance, IMCAs can and do. IMCAs directly facilitate the protection of rights by assisting people to participate in decisions affecting them and advocating on their instructions. If they cannot get instructions from the person, they will provide ‘non-instructed advocacy’, which is different from best interests advocacy.⁴⁹² Lawyer Tam Gill noted that IMCAs are very useful as they have broad powers and ‘can make things happen’.⁴⁹³

There are also specialist DOLS IMCAs, who help the person to understand:

- ‘Why they meet the criteria for authorisation of deprivation of liberty;
- ‘Any conditions to which the authorisation is subject and how long it will last;
- ‘The effects of the authorisation and what it means;
- ‘Their right to request a review; [and]
- ‘Their right to make an application to the Court of Protection to seek variation or termination of the authorisation’.⁴⁹⁴

If an IMCA comes across a person who needs or would benefit from legal assistance, they can facilitate contact with a lawyer.

Pre-emptive rights-based education: Hungary

Tamás Verdes identified the biggest problem for the sector in Hungary as being that people with disabilities, particularly those in institutions, do not seek legal assistance. For him, having too many people seeking legal help ‘would be a very good problem to have’. While funding is in theory available for representation, most people do not know they have these rights and they are often not (meaningfully) told of their rights or are misled as to their rights.⁴⁹⁵ When Tamás and I visited Reménysugár Habilitációs Intézet (‘Ray of Hope’), a 116 bed institution for people with multiple and profound disabilities on the outskirts Budapest, the deputy director told me that ‘there has never been a case where a person here needed a lawyer’. However, this seemed entirely dubious given (she told me) all except one residents are under guardianship plus the facility had been the subject of a scandal in 2012 after 21 neighbours wrote to the Hungarian Minister for Human Resources about abuse they observed being perpetrated on residents by staff.⁴⁹⁶

⁴⁹² ‘Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to give a clear indication of their views or wishes in a specific situation. The non-instructed advocate seeks to uphold the person’s rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for their unique preferences and perspectives’: Office of the Public Guardian (UK), above n 142, 9.

⁴⁹³ Tam Gill.

⁴⁹⁴ seAp, ‘What does a DOLS IMCA do?’ <<http://www.seap.org.uk/services/deprivation-of-liberty-safeguards/about-dols-advocacy.html>>.

⁴⁹⁵ Tamás Verdes.

⁴⁹⁶ See MDAC, ‘Hungary: Is there no hope in the ‘Ray of Hope’?’ (September 2012) <http://www.mdac.org/en/07/09/2012/hungary_is_there_no_hope_in_the_ray_of_hope>.

‘where people have power over others, it needs exceptional leadership for it not to go wrong’.

– South Australian Public Advocate John Brayley

The Hungarian government does fund ‘advocates’ to provide services at social care institutions. However, both Dr Adrienn Gazsi and Tamás Verdes were critical of their ability to achieve anything as they are not lawyers and are not properly independent of the facilities (usually having strong connections with the managers, who are often also the guardians).

Accordingly, Tamás has developed a new project to engage with children and young people with disabilities who are still at school, as ‘school is the last place we can reach these children’⁴⁹⁷ before they disperse and are potentially closed away in institutions. The project involves a card game about human rights risk areas, to teach the basics of legal issues that have human rights implications and to build awareness of the right to and benefit in seeking legal assistance (given the difficulty in finding a suitable lawyer in Hungary, the best advice Tamás could come up with to include in the card game about accessing a lawyer was to go to the internet and do a google search). It is intended that teachers and parents will use the game with the young people. Tamás told me he was hosting a meeting with five schools in September 2015 to promote the project. His hope is that at least some of the young people who are exposed to this game will remember the key messages and seek legal help if they need it in future.

Engaging with and influencing those who go behind closed doors: Hungary

Statutorily appointed inspectors like Ombudsmen and designated human rights monitors (such as organisations appointed as the national preventive mechanism – ‘NPM’ – to monitor implementation of rights under the Convention against Torture and CRPD) can play a significant role in identifying legal issues and people behind closed doors who are in need legal advocacy. Furthermore:

The range of powers and authority for these various bodies is enormous and human rights lawyering organi[s]ations should take full advantage of such entities to advance their own objectives for change.⁴⁹⁸

As it operates in many different countries with only a very small staff, MDAC has established relationships with various human rights monitors in the jurisdictions in which it works to gather information, generate legal referrals and collaborate on common causes. Since January 2015, the Hungarian Ombudsman has functioned as the NPM for Hungary. In May 2015, he produced a shocking report regarding the treatment of people with disabilities in institutions, including the use of cage beds. Following the report, MDAC wrote to the Prime Minister calling for an investigation, publicity of findings, training for staff and other measures to protect human rights.

While monitoring can detect past and current abuses, its key function is really to prevent such abuses from occurring in the future through deterrence and education:

The respect and protection of human rights cannot be assured unless and until the cloak of invisibility, so common to institutions, is lifted. The most effective way of removing this cloak is through the active use of independent inspectorates because without them, neglect and abuse will continue with impunity, and will continue to be unnoticed and unremedied.⁴⁹⁹

Accordingly, for MDAC, influencing the monitors is also part of their strategy to protect the human rights of people with disabilities. For example, a few years ago, MDAC noticed that over the first years of operation of the UN Sub-committee on the Prevention of Torture (‘SPT’), the SPT had conducted monitoring visits at over 200 places in 30 countries, yet only four places were hospitals and only two of those were psychiatric hospitals.⁵⁰⁰ MDAC called on the SPT to not open itself to a discrimination claim and to rebalance its resources to also monitor disability facilities.

⁴⁹⁷ Tamás Verdes.

⁴⁹⁸ Richard Wilson and Jennifer Rasmussen, *Promoting Justice: A practical guide to strategic human rights lawyering* (International Human Rights Law Group, 2001) 83.

⁴⁹⁹ ITHACA Project Group, *ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions* (Health Service and Population Research Department, Institute of Psychiatry, King’s College London, 2010) 23.

⁵⁰⁰ Oliver Lewis. See also Oliver Lewis and Dorottya Karsay, ‘Disability, torture and ill-treatment: taking stock and ending abuses’ (2012) 16(6) *International Journal of Human Rights* 816.

Conclusion

As the South Australian Public Advocate John Brayley told MDAC staff when he visited in July 2015, ‘where people have power over others, it needs exceptional leadership for it not to go wrong’. As noted in the introduction, exposés and reports in recent years have highlighted concerning levels of abuse of people with disabilities behind closed doors in Victoria. Alex Ruck Keene and Peter Edwards both stated that the people who (are said to) lack capacity and are not asking for help or expressing their concerns are the most in need of advocacy and the most important to help as they otherwise have no voice.

In the absence of any clear role or mandate for lawyers to go behind closed doors and approach informally detained people, it is even more important that the independent inspectors and others who do have such functions are properly resourced and carrying out their functions effectively, including identifying and referring on people who may benefit from legal assistance.

In June 2015, in phase one of her investigation into the reporting and investigation of allegations of abuse in the disability sector, the Victorian Ombudsman concluded that there is inadequate funding for disability advocacy.⁵⁰¹ Building on the Ombudsman’s recommendations, the interim report of the Victorian parliamentary inquiry into abuse in disability services (tabled in Parliament in August 2015) seeks to explore how such an advocacy scheme should work.⁵⁰² Its final report will be delivered by 1 March 2016. If delivered, such an advocacy scheme could prove to be a very significant element in the currently limited rights protection framework for people who are informally detained in Victoria.

RECOMMENDATIONS AND IDEAS

- ▶ Building on the VLRC’s 2012 guardianship review, seek to engage the government to develop an appropriate response to ensure the rights of informally detained people are protected.
- ▶ Support the recommendations of the Victorian Ombudsman and the Victorian parliamentary committee inquiry to properly fund a Victorian disability advocacy scheme and ensure that the operators of that scheme, if established, understand when and how lawyers can assist.
- ▶ Develop relationships with disability service inspectors and visitors, such as community visitors, so they understand what issues lawyers can assist with and how to make appropriate referrals.
- ▶ Consider modifying VLA’s ‘Learning the Law’ education package for special schools⁵⁰³ to create resources suitable for special developmental school students (who have more significant disabilities), to assist them to understand when they might benefit from seeking legal assistance in the future.

⁵⁰¹ Victorian Ombudsman, above n 9, 2015.

⁵⁰² Family and Community Services Committee, Parliament of Victoria, above n 9.

⁵⁰³ See VLA, ‘Learning the law’, above n 1.

CHAPTER 4:

BEYOND INDIVIDUAL LEGAL SERVICES: STRATEGIC ADVOCACY

The actions described in Chapter 3 involve lawyers working within domestic legal frameworks on behalf of individual clients. This chapter looks at why and how disability legal services and other legal organisations engage in **strategic advocacy** – advocacy designed to improve laws and practices that negatively impact on people with disabilities detained for compulsory treatment in a systemic way, rather than just at an individual level. It comprises three sections:

- A. Why lawyers should engage in strategic advocacy;
- B. Setting the scope and goals of rights-based strategic advocacy; and
- C. Engaging in strategic advocacy.

4A. WHY LAWYERS SHOULD ENGAGE IN STRATEGIC ADVOCACY

There is only so much a lawyer can do to protect their client's human rights in an individual case if:

- The laws, procedures and/or policies governing their situation are fundamentally unfair, inconsistent with human rights or fail to provide essential rights safeguards; or
- Laws, procedures and policies which are rights-protecting on their face are nevertheless routinely interpreted and applied in a way which does not protect those rights.

Faced with these circumstances, lawyers may seek to change the system itself rather than just working within its limits.

By pursuing systemic change, lawyers promote and seek to protect the rights of a broad cohort of people similarly affected by the particular limitations of the system, many of whom may have never even spoken with a lawyer. Achieving systemic change also prevents people from being negatively impacted by the same issue in the future. Accordingly, lawyers can make a tremendous impact through strategic advocacy in ways which are unlikely to be achieved through legal services that focus purely on the interests of the individual client before them.

Reflecting on his 40 years in the field, Emeritus Professor Michael Perlin said that ‘[n]o systemic change happens without lawyers’. He therefore stressed the importance of lawyers taking action to shape the domestic legal and structural frameworks which restrict the rights of people with disabilities:

[I]t is essential that lawyers representing patients have the capacity to engage in law reform/test case/public interest affirmative litigation.⁵⁰⁴ There is no question that one of the most critical aspects of law reform is the presence of dedicated and knowledgeable counsel.⁵⁰⁵ Without the assignment of such counsel, meaningful and ameliorative change is almost impossible to achieve.⁵⁰⁶ [Without] adequate counsel, no judicial system can work effectively to protect human rights for a person when his or her human rights are infringed.⁵⁰⁷ As I wrote seven years ago:

To be authentically effective, counsel needs to be available both for individual cases (in which commitment of the patient is being sought) and in “affirmative” cases (that is, cases consciously thought of as “public interest” or “law reform” cases in which persons with disabilities file suit as plaintiffs seeking variously to have courts articulate procedural or substantive due process rights in the commitment process, or to have courts articulate such rights with regard to conditions of confinement, the latter encompassing both positive rights, e.g., a right to treatment services, and negative rights, e.g., the right to refuse treatment).⁵⁰⁸

The presence of a vigorous, independent advocacy system (with trained, speciali[s]ed counsel) is perhaps the most critical issue in determining whether any true mental health law reform is possible in any jurisdiction.⁵⁰⁹ And, without such counsel, the meaningful implementation of rulings in class action/law reform cases and/or appellate decisions will be virtually impossible.⁵¹⁰ We know that representation is rarely made available to patients in a systemic way in law reform or test cases, and we also know that “It is only when counsel is provided in an organi[s]ed, speciali[s]ed and regulari[s]ed way that there is more than a random chance of lasting, systemic change.”⁵¹¹ Without the presence of effective counsel, substantive mental disability law reform recommendations will likely turn into “an empty shell”⁵¹² (citations in original).

Many lawyers I met also shared these views, although the extent to which they participated in deliberate, strategic advocacy varied (see Part 4C below).

⁵⁰⁴

For a description of the first such office and its early litigation successes that led to significant and long-lasting reform in one state’s mental health system, see Michael L. Perlin, ‘Mental Patient Advocacy by a Patient Advocate’ (1982) 54(3) *Psychiatric Quarterly* 169.

⁵⁰⁵

Michael L. Perlin, ‘Online, Distance Legal Education as an Agent of Social Change’ (2011) 24 *Pacific McGeorge Global Business and Development Law Journal* 95, 104.

⁵⁰⁶

Ibid.

⁵⁰⁷

Michael L. Perlin, ‘Promoting Social Change in Asia and the Pacific: The Need for a Disability Rights Tribunal to Give Life to the UN Convention on the Rights of Persons with Disabilities’ (2012) 44 *George Washington International Law Review* 1, 30.

⁵⁰⁸

Perlin, ‘“I Might Need a Good Lawyer, Could Be Your Funeral, My Trial”’, above n 242, 263.

⁵⁰⁹

Michael L. Perlin, ‘“Chimes of Freedom”: International Human Rights and Institutional Mental Disability Law’ (2002) 21 *New York Law School Journal of International and Comparative Law* 423, 426.

⁵¹⁰

Perlin, ‘“And My Best Friend, My Doctor/ Won’t Even Say What It Is I’ve Got”’, above n 243, 748.

⁵¹¹

Perlin, ‘“You Have Discussed Lepers and Crooks”’, above n 240, 708.

⁵¹²

Michael L. Perlin and Deborah A. Dorfman, ‘Is It More Than “Dodging Lions and Wastin’ Time”? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases’ (1996) 2(1) *Psychology, Public Policy and Law* 114, 121.

4B. SETTING THE SCOPE AND GOALS OF RIGHTS-BASED STRATEGIC ADVOCACY

As acknowledged in the introduction, the very idea of seeking to protect the human rights of people with disabilities who have been detained for compulsory treatment has numerous, contested meanings. Accordingly, there is considerable variation in the scope of action and substantive goals which lawyers might set for rights-based strategic advocacy on behalf of people with disabilities who have been detained for compulsory treatment.

On the narrowest approach to rights protection, lawyers may focus simply on protecting the specific rights to liberty and freedom from compulsory treatment – the rights most obviously limited by compulsory treatment laws – to the extent allowed by their domestic legal system. However, broader and possibly more sophisticated goals for consideration – which I explore below – include:

- Seeking compliance with international human rights and the CRPD;
- Promoting and seeking protection for a broader range of rights, including ‘positive’ rights to treatment and community-based supports; and
- Tackling issues which affect a specific cohort of people with disabilities (such as intersectional disadvantage and discrimination), rather than dealing only with general disability issues.

Seeking compliance with international human rights and the CRPD

As noted in the introduction, there is an unresolved debate as to whether compulsory treatment can ever be compatible with human rights and, if it is possible, what CRPD-compliant compulsory treatment laws would actually look like.

Is compulsory treatment compatible with the CRPD?

When it ratified the CRPD in 2008, Australia ‘declared its understanding that the CRPD allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person [for instance, in relation to treatment], only where such arrangements are necessary, as a last resort and subject to safeguards’.⁵¹³ However, in 2013, the CRPD Committee recommended that Australia ‘repeal all legislation that authori[s]es medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community’.⁵¹⁴

Whether compulsory treatment can ever be compatible with human rights, particularly if the person subjected to that treatment has the capacity to make their own decisions about treatment, is contested. This was evident in the presentations and discussions between lawyers, academics, service users and, to a lesser extent, clinicians during the conferences I attended. The debate was recently fuelled by the release of the CRPD Committee’s ‘general comment’ on article 12 of the CRPD (equal recognition before the law) in May 2014, which states:

[F]orced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the [CRPD]... States parties must abolish policies and legislative provisions that allow or perpetrate ppggppforced treatment.⁵¹⁵

⁵¹³ *Convention on the Rights of Persons with Disabilities: Declarations and Reservations* (Australia), opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

⁵¹⁴ United Nations Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Australia*, adopted by the Committee at its 10th session (2–13 September 2013), 5 [32c], [34].

⁵¹⁵ United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1 - Article 12: Equal recognition before the law* (adopted 11 April 2014) [42].

‘if you’re on the ground and face to face with the experience of humans suffering, you can’t ignore that.’

– Washington DC peer advocate Yvonne Smith, on the need for individual legal services as well as strategic advocacy

Dr Lucy Series explained just how contested the notion of human rights in this field now is:

On one influential view, a view shared by the [CRPD Committee], the CRPD does not permit compulsory treatment or detention on disability-related grounds (including disability + risk, or disability + incapacity). There are lots of variants on this view. For example, some believe that the CRPD does permit laws like the [MCA], but not the [MHA (UK)], so long as they remove something called the ‘diagnostic threshold’ in s 2(1) MCA, and tailor ‘best interests’ to place a stronger emphasis on [the] ‘will and preferences’ [of the person]... Others, like Tina Minkowitz, think that the CRPD doesn’t permit forced treatment or detention ever. Others... think that the CRPD actually does, but that it shouldn’t. Then [yet other] people... have been looking at whether other legal mechanisms, like the duty of care or doctrine of necessity could manage emergency situations on disability-neutral grounds without providing fully-fledged forced treatment and detention frameworks.

While acknowledging this debate is important and ongoing, it is beyond the scope of this report to contribute an opinion on it.

Notwithstanding their variable interpretations of what compatibility with the CRPD looks like, many people and organisations I met rely on international human rights standards as the basis for their strategic advocacy in this area, seeking to maximise the compatibility of domestic laws with international human rights law.

In fact, at one extreme, some people feel strongly that any advocacy done within the confines of an incompatible domestic system (as opposed to advocacy directed at rewriting those frameworks to make them compatible with international human rights law), cannot be considered rights-based work. For instance, very early on in my travels, Tina Minkowitz, president of the New York-based Center for the Human Rights of Users and Survivors of Psychiatry (and a lawyer herself), said to me:

I don’t put my energy into thinking about [the operation of domestic legislation and the role of lawyers] any more because the only answer both from a practical point of view and from a principled point of view is to abolish commitment and forced treatment and get rid of the whole framework that creates a necessity for this legal representation. I think that, post-CRPD, it is a responsibility of everyone who is concerned with human rights in relation to mental health law to acknowledge that commitment and forced treatment are human rights violations, and that [S]tates [P]arties to the CRPD have an obligation to abolish these practices and abolish the laws that allow them to take place.⁵¹⁶

In contrast, Washington DC peer advocate Yvonne Smith felt it was a lofty ideal for advocates to focus entirely on overthrowing systems of compulsory treatment as a violation of international human rights law but, ‘if you’re on the ground and face to face with the experience of humans suffering, you can’t ignore that’. Accordingly, she felt it was legitimate and appropriate for human rights lawyers to work on assisting people and improving their situation *within* the system as well.

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She has set out her views about what CRPD-compliant mental health legislation would look like on the blog, *Mad in America* (11 May 2015) <<http://www.madinamerica.com/2015/05/what-would-crp-compliant-mental-health-legislation-look-like/>>.

'I think that's where the State is falling down and somebody should be calling them on it.'

– Lisa Volpe, MHLS, New York, on how the failure to provide sufficient stable housing leads to preventable loss of liberty

MDAC operates primarily in jurisdictions where the domestic protection of rights is often sorely lacking and so it relies heavily on international human rights law in its advocacy. MDAC is well aware of the contested nature of human rights discourse. Campaigns director Steven Allen described how MDAC is often stuck between criticisms from the user and survivor movement, on the one side, saying they are not doing enough and governments and psychiatrists, on the other, telling them they do not recognise the scale of change required. For instance, the Bulgarian judiciary has criticised MDAC for moving too fast in seeking full abolition of guardianship, despite article 12 of the CRPD containing rights which are civil and political in character and therefore attract immediate implementation obligations under international human rights law.

Whatever your understanding of human rights, Steven said it is important for an organisation to consider and come up with a principled position in order to campaign and participate in debates. While MDAC measures itself against the human rights ideals it aspires to implement, it also recognises the reality in which it operates and acknowledges incremental improvements towards human rights compliance. MDAC's litigation director Ann Campbell said that while you should use human rights language every opportunity you get, if it is not strategic to do so – for instance, if people will not understand or be responsive – do not be afraid to use other approaches.

Despite the complexity (and ostensible irrelevance to day-to-day, domestic lawyering) of the high-level, conceptual debates about what human rights mean, academic Dr Piers Gooding (who has just returned to Melbourne after working at the Centre for Disability Law and Policy in Galway, Ireland), felt that it was important for people to not shy away from them.⁵¹⁷ He said it is of no great assistance to get the law right if the people operationalising it do not 'get' it, because they will otherwise intuit and work backwards from their own ideas. He therefore emphasised the need to instil an understanding of the theoretical and conceptual underpinnings of the CRPD in those working with people with disabilities – to 'win their hearts and minds'.

The importance of positive rights and adequate community services

Negative rights require the State to refrain from acting against a person in a particular way, such as the rights to liberty, to privacy and to be free from treatment without consent.

Positive rights impose obligations on the State to take action, such as the rights to housing and to health care.

When working with people with disabilities detained for compulsory treatment, it is understandable that lawyers focus much of their energy in seeking to protect the negative rights which have been most overtly and acutely restricted by the law, namely the rights to liberty and to be free from treatment without consent. However, this is in some respects a short-sighted approach. The supposed distinction between positive and negative rights is really a false dichotomy as 'failing to uphold [positive] social, economic and cultural rights can lead to preventative loss of [negative] civil and political rights'.⁵¹⁸

⁵¹⁷ Speaking at the IALMH conference in Vienna, July 2015.

⁵¹⁸ John Brayley, Public Advocate for South Australia, speaking to staff at MDAC, 20 July 2015.

Just as I have witnessed in Victoria, people I met in each jurisdiction told me that the non-availability of adequate accommodation and community supports mean that people with disabilities are detained in hospital for longer than they may clinically require and are (re)admitted to hospital in circumstances where it would not have been necessary if they had had adequate community services and supports in place. For example, Dr Lucy Series said of England:

All kinds of services – mental health, housing, social care – are massively under-resourced, and so are unable to properly support people to live in the community. The fact that home care services aren't properly resourced means people may be forced into residential care. Housing is increasingly a massive problem in the UK. The fact that mental health services aren't properly resourced means that services don't respond until people are in crisis, and then it may be too late to offer consensual support and much harm may have been done.

Similarly, in New York, MHLS' Lisa Volpe said that inadequate funding for appropriate housing was a key issue still in need of strategic litigation, as many people are detained in hospital or held in more restrictive circumstances than necessary simply due to lack of appropriate accommodation:

In the federal nursing home litigation [see box 'Monitoring the settlement in *Joseph S v Hogan*: New York' in Part 4C below], part of the settlement was that people who were wrongfully put into nursing homes and who don't need to be there get moved into the community and they've done some but really very little of it in the five years since it's been settled. I think the big problem (for not just those individuals, but [for] those individuals who are now being moved into the community because they are shutting down the hospitals) is that there's not enough housing, so in the absence of stable housing, it's very hard to keep up with the services and keep a person from cycling in and out of the hospital. So to me, a focus for somebody, although MHLS just doesn't have the ability or maybe even the mandate to deal with it, is that the State should be putting their funds into housing for the disabled and somebody should be doing systemic litigation on that issue, it's extremely important. I would love to be able to do that and I think that's where the State is falling down and somebody should be calling them on it.

The CRPD reaffirms the 'universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms'.⁵¹⁹ Accordingly, focussing only on negative rights without also addressing access to education, housing, treatment, financial support, employment and community integration – and ensuring that funding is appropriately directed towards such measures – will be insufficient to protect the rights of people with disabilities. As Tamás Verdes, who leads the disability rights program at the HCLU, noted, without access to accommodation and other supports, pursuing deinstitutionalisation on behalf of a client becomes little more than helping them become homeless.

Furthermore, positive rights are intrinsically connected to the social model of disability articulated in the CRPD, whereby 'disability' is not the impairment which an individual has but rather 'results from the *interaction between* persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others' (emphasis added).⁵²⁰ By addressing the attitudinal, environmental and structural barriers to community participation, for instance through the provision of adequate supports adjusted to the individual, disability will in fact be reduced. While Australia is quite good at providing reasonable accommodations for people with physical and sensory disabilities, it is still not so good when it comes to accommodations for people with cognitive and mental disabilities.⁵²¹

Speaking at the IALMH conference in Vienna in July 2015, Victorian Associate Professor Penny Weller noted that Victoria's mental health laws do not provide any recognition or rights protections for people exiting or outside of the compulsory treatment system. She also said that there is not enough talk enough about positive entitlements and called for greater exploration of CRPD articles beyond article 12.

⁵¹⁹ CRPD Preamble (c).

⁵²⁰ CRPD Preamble (e).

⁵²¹ John Brayley, 'Supported Decision-Making: A Population Based Model for Upholding Article 12 of the UN CRPD' (presentation at the IALMH conference, Vienna, July 2015).

Similarly, in a recent article published during this project, Melbourne academics Professor Bernadette McSherry and Kay Wilson called for a move away from debates on the meaning of capacity and whether or not compulsory treatment is permissible, and argued that a greater focus on the positive obligations of States under the CRPD to provide adequate services and supports, adapted to the individual needs of people with disabilities, may be more important to realise the aims of the CRPD:

It makes little sense to focus on gaining legal capacity to make mental health care decisions in a mental health system which gives minimal care and treatment options in which to actually exercise the hard-won “right to choose”...

... a focus on shifting resources to the voluntary sector may be ultimately more important in implementing the CRPD, giving persons with mental impairments real self-determination and lifting their status and participation in society, than legal debates about the precise meaning of Article 12 of the CRPD...

Instead of getting tangled up in capacity and “disability neutral” matters, the focus for policymakers should be on the positive rights set out in the CRPD. By shifting the focus away from involuntary detention and treatment to providing and funding high quality services and support systems adapted to individual needs, the CRPD highlights that there may be a midway point between involuntary treatment on the one hand and no treatment at all on the other. More importantly, the need for involuntary treatment may diminish or disappear altogether...

Ultimately, it is only by emphasising the obligations placed on States Parties and, in particular, the obligation to provide services adapted to individual needs, that the law can be used to bring about true reform in mental health care and treatment.⁵²²

One thing that surprised me during this project was how many mental health and disability law organisations and programs do focus on protecting their clients’ positive rights, including rights to shelter/housing, to treatment and to access services – rather than simply negative rights. In fact, much of the strategic litigation relating to disability rights in the US invokes the ADA, a revolutionary piece of legislation enacted in 1990 which prohibits a wide range of discrimination on the basis of disability (for example, see box below). The ADA is fundamental for mental health and disability lawyers in the US, including those who primarily focus on assisting people detained for compulsory treatment, because of the interrelation between rights (see Part 4C below).

The *Olmstead* decision

The 1999 US Supreme Court decision of *Olmstead v LC*⁵²³ has been described as ‘the most important civil rights decision for people with disabilities in [US] history’.⁵²⁴ Based on the ADA, the Supreme Court held that people with disabilities have a qualified right to receive state-funded supports and services in the community rather than institutions when the following three-part test is met:

- The person’s treatment professionals determine that community supports are appropriate;
- The person does not object to living in the community; and
- The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

In Budapest, MDAC’s campaigns director Steven Allen said that litigating positive rights – such as the requirement for the State to provide individualised, community-based accommodation – is often the hardest part of their task but is critically important. He described it as the ‘real frontier in our field’ to reconceptualise welfare state notions of entitlements and public good into human rights terms, and to persuade courts to find that authorities must take specific actions to ensure people with disabilities can enjoy their rights. While litigating civil and political rights remains necessary and a core part of MDAC’s strategy, Steven believes MDAC should focus some more of its limited resources and expertise on advocating for the implementation of positive obligations. To assist in the uptake of this work, MDAC has produced a handbook for lawyers on ‘litigating the right to community living for people with mental disabilities’.⁵²⁵

⁵²² Bernadette McSherry and Kay Wilson, ‘The concept of capacity in Australian mental health law reform: Going in the wrong direction?’ (2015) 40 *International Journal of Law and Psychiatry* 60, 67-68.

⁵²³ 527 US 581 (1999).

⁵²⁴ Olmstead Rights, ‘The Olmstead Supreme Court Decision in a Nutshell’ <<http://www.olmsteadrights.org/about-olmstead/>>.

⁵²⁵ MDAC, *Litigating the right to community living for people with mental disabilities: a handbook for lawyers* (2014).

Unlike Victoria, provisions in domestic statutes in both New York and England impose specific obligations on hospitals and related services to provide adequate services and supports for people being discharged from hospital (in relation to England, see box below), which give lawyers in these jurisdictions a more direct means of advocating on behalf of their clients around these issues.

After-care services in England

In England, s 117 of the MHA imposes a joint duty on the Clinical Commissioning Group ('CCG') and Local Social Services Authority to provide 'after-care services' in respect of most people⁵²⁶ detained for treatment under the MHA.

As amended from April 2015, 'after-care services' is defined to mean services which have both of the following purposes:

- Meeting a need arising from or related to the person's mental disorder; and
- Reducing the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to hospital again for treatment for mental disorder).

The Code of Practice requires CCGs and local authorities to interpret this definition broadly:

For example, after-care can encompass healthcare, social care and employment services, supported accommodation and services to meet the person's wider social, cultural and spiritual needs, if these services meet a need that arises directly from or is related to the particular patient's mental disorder, and help to reduce the risk of a deterioration in the patient's mental condition.⁵²⁷

The duty 'begins when the person ceases to be detained and (whether or not immediately after so ceasing) leaves hospital'.⁵²⁸ However, 'the planning of after-care needs to start as soon as the patient is admitted to hospital'⁵²⁹ (despite this planning obligation, CQC audits found no evidence of discharge planning in 29% of records examined in 2014-2015⁵³⁰).

The duty to provide after-care continues until the CCG and local authority are both satisfied that such services are no longer required (which cannot be during the operation of a CTO).

The House of Lords has decided that no charges may be made for after-care services.⁵³¹

However, where such statutory or other legal duties exist but are not supported by adequate funding or resources, lawyers noted that they can have counterproductive effects and can prolong a person's detention. For instance, in New York, community services and social services officials are under a statutory duty to see 'that all mentally ill persons within their respective communities who are in need of care and treatment at a hospital are admitted to a hospital',⁵³² and hospitals are under a statutory obligation to do safe discharge planning before releasing a person. Despite regulations and policies suggesting that hospitals should not discharge people to homeless shelters, people still end up there:

[I]f somebody says, "I don't really care, just get me out of here", they'll send them to a shelter. It's probably not the best planning but if that's what somebody is willing to do and [the MHLS is] there to say you can't hold this person any longer because they don't meet the legal standard for confinement, then the hospital's going to let them out. I don't think that's the best or even their preferred discharged planning however in their favour.⁵³³

Sometimes, in an effort to speed up their release, the court will call in agencies with responsibilities towards the person to get them to explain their inability to provide adequate accommodation. Even if the criteria for detaining the person are not met, the court in its discretion can stay the order for release – which continues the person's detention – to give the hospital more time for discharge planning. Sara Rollyson explained her frustrations around this:

We will put pressure on the hospital to make sure they are doing their job and check up on them. I mean it is frustrating... My personal opinion is that we have the law on our side and someone shouldn't have to stay in a hospital for a bed if they are willing to go to a shelter and some of our clients are.

⁵²⁶

The duty does not extend to section 2 patients, who have only been admitted for up to 28 days.

⁵²⁷

Department of Health (UK), *Code of Practice*, above n 95, [33.4].

⁵²⁸

MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 73; *Mental Health Act 1983* (UK) s 117(1).

⁵²⁹

Department of Health (UK), *Code of Practice*, above n 95, [33.10].

⁵³⁰

CQC, *Monitoring the Mental Health Act in 2014/15*, above n 83, 44.

⁵³¹

R (Stennett) v Manchester City Council [2002] UKHL 34.

⁵³²

Mental Hygiene Law § 9.47.

⁵³³

Lisa Volpe.

Not just disability: intersectional discrimination and other rights issues

People with disabilities are clearly not an homogenous group and should not be defined by their disability. Not only will attitudinal and environmental barriers relating to their particular disability impact on the realisation of their rights, additional barriers may also arise from other characteristics such as gender or culture, and the intersection between those characteristics and their disability. In focusing on disability rights, it is important not to ignore needs arising from these other dimensions or the intersection between them.

I saw examples of this in my travels. Recognition of the cultural rights of people with mental illness has led, for instance, to the creation of a number of Spanish, Chinese and Korean-language psychiatric wards in New York City and, in Western Australia, the Mental Health Tribunal is looking at how to deliver 'culturally secure review processes' for indigenous consumers and their families.⁵³⁴

Lawyers in the US also spoke about actions they took on behalf of clients receiving compulsory treatment to address intersectional forms of discrimination and disadvantage. For instance, Sara Rollyson described how part of the MHLS' role is to ensure that treatment is accessible to patients with multiple disabilities and/or alternative language needs, which may hinder their participation in mainstream treatment and rehabilitation activities. In terms of how the MHLS acts to make sure those rights are respected, she said 'it depends, a lot of times it's just talking to [the service]'.⁵³⁵ Sara also noted that sometimes Kings County Hospital is responsive to them mentioning the court-approved settlement agreement they have with them (see box 'Fight to improve conditions at Kings County Hospital: *Hirschfeld vs New York City Health and Hospitals Corporation*' in Part 4C below). If the MHLS raises the need to provide accessible treatment or therapy in a language other than English, they apparently will not be met with a response that the resources do not exist or that it is too expensive for one individual:

[T]hey might not be able to have a full group but there will be a phone they can use to translate everything. We have had clients that are deaf and mute and that is a different level, but we try to make sure that they are getting some sort of services... How are you diagnosing them if you can't even talk to them?... Plus it's Brooklyn. I don't know if Melbourne is the same but it's so diverse here, so to say that you can't provide [it]...⁵³⁶

MDAC is also increasingly focusing on intersectional forms of discrimination affecting, for instance, children with disabilities and women with disabilities. Steven Allen said this amplifies the strategic value of their work, plus also opens up new partners for collaboration (for example, they are collaborating with the European Roma Rights Centre to tackle the shared issue of segregation in education).

Reflections

As practising lawyers in Victoria, MHDL's primary focus is on seeking compliance with domestic mental health and disability laws and we are quite disconnected from the international debates about what 'true' compliance with human rights looks like. This focus is born of a number of factors, including:

- The difficulties we face just in trying to secure compliance with the letter and spirit of domestic laws;
- The difficulty in getting tribunals and courts to properly engage with human rights arguments, which is exacerbated by the lack of a free-standing cause of action to seek a remedy where a public authority has acted incompatibly with human rights;⁵³⁷
- The absence of a regional human rights court to which human rights issues can be escalated;⁵³⁸
- The comparative weakness of Australia's human rights culture and the disregard shown by parts of government towards international human rights standards;⁵³⁹ and
- A practical pragmatism arising from working face-to-face with the existing system and the people caught up in it under pressured conditions, which allows little time to step back, look at what is happening in other jurisdictions and consider often highly conceptual and nuanced ideas about what true rights compliance means and how we could achieve it.

Despite these challenges, it is incumbent on lawyers practising in this area to at least be aware of the contested nature of the laws with which they work.

⁵³⁴ Southalan, above n 22.

⁵³⁵ Sara Rollyson.

⁵³⁶ Ibid.

⁵³⁷ As noted above, the creation of such a cause of action was recently formally recommended: Brett Young, above n 397, viii.

⁵³⁸ Michael Perlin has been advocating for the creation of a Disability Rights Tribunal for the Asia-Pacific for some years, see eg Perlin, 'Promoting Social Change in Asia and the Pacific', above n 507.

⁵³⁹ This was most publicly evidenced by then Prime Minister Abbott's comment in March 2015 that 'Australians are sick of being lectured to' by the UN and the federal government's repeated attacks on Australian Human Rights Commission President Gillian Triggs, see Lisa Cox, 'Tony Abbott: "Australians are sick of being lectured to" by United Nations, after report finds anti-torture breach', *Sydney Morning Herald* (10 March 2015).

... the State will not take its responsibilities under the CRPD seriously if lawyers practising in the area do not show an interest in it and demand compliance.

Furthermore, the State will not take its responsibilities under the CRPD seriously if lawyers practising in the area do not show an interest in it and demand compliance. Even if MHDL lawyers are not the ones actively campaigning for this, we can assist others. For instance, being such a high volume legal service working across a range of relevant practice areas, VLA is in possession of a great deal of pertinent information about the practical operation of laws which could be shared with the civil society organisations preparing their shadow report for the CRPD Committee's next periodic review of Australia's CRPD compliance in 2018.

Aside from its domestic focus, MHDL also focuses principally on protecting its clients' negative rights – the rights to liberty and to be free from forced treatment and other interferences with privacy and autonomous decision-making – rather than their interrelated positive rights. Other parts of VLA focus on anti-discrimination and areas of law more connected to positive social and economic rights (including housing and social security) and MHDL clients are referred to these and/or external services where appropriate. However, VLA does not often actively discuss the intersection between this work and that of MHDL, nor approach those issues from an express disability rights perspective, despite systemic disability rights issues arising in all practice areas.⁵⁴⁰

RECOMMENDATIONS AND IDEAS

- ▶ Explore ways of strengthening the human rights culture in Victoria.
- ▶ Organise information sessions and discussions with academics and others knowledgeable about the CRPD to inform both MHDL's practice as well as that of the non-disability-specific practice areas of VLA.
- ▶ Consider introducing CRPD-modelled arguments into advocacy.
- ▶ Consider the applicability of and, where relevant, include CRPD obligations in all legislative and policy reform submissions.
- ▶ Identify and inform other advocacy organisations of VLA's willingness to support their advocacy for better CRPD compliance and assist them where possible, for instance with the sharing of ideas and information.
- ▶ Consider how best to collect and share data relating to human rights abuses.
- ▶ Advocate for laws and policies that promote positive rights, including proper investment in the NDIS and community services.
- ▶ Explore ways to advance disability rights in VLA's non-disability-specific practice areas.
- ▶ Establish a network for MHDL to collaborate with non-disability-specific sections of VLA and external agencies to better understand the intersection of the work and systemic disability rights issues, with a focus on positive rights.

⁵⁴⁰

For instance, the children of parents with disabilities are removed by the child protection system at alarmingly high rates: Office of the Public Advocate, *Rebuilding the Village*, above n 12.

4C. ENGAGING IN STRATEGIC ADVOCACY

Even once the thematic area of focus and substantive goals are determined, there are so many other variables and possible approaches when it comes to strategic advocacy. In undertaking this research, I wanted to learn about how other organisations go about engaging in strategic advocacy. Specifically, I explored:

- How organisations balance individual legal services with strategic activities;
- To what extent they engage in planning and priority-setting;
- How they approach and conduct strategic litigation;
- What other strategic advocacy tools they use; and
- Whether and how they collaborate when doing strategic advocacy.

As well as the mental health legal services discussed earlier, I discuss a number of other organisations in this part that engage in strategic advocacy on behalf of people with disabilities which I have not mentioned elsewhere in the report. These include:

- Disability Rights New York ('**DRNY**'), New York;
- MFY Legal Services, Inc. ('**MFY**'), New York;
- The Mental Health Association of New York City ('**MHA-NYC**'), New York;
- The Judge David L. Bazelon Center for Mental Health Law ('**Bazelon**'), Washington DC;
- The American Civil Liberties Union ('**ACLU**'), Washington DC;
- Disability Rights International ('**DRI**'), Washington DC;
- Mental Disability Advocacy Centre ('**MDAC**'), Budapest;
- Társaság A Szabadságjogokért (Hungarian Civil Liberties Union, or '**HCLU**'), Budapest; and
- Liberty, England.

I have set out some background information and further detail about the scope and operation of these organisations in Appendix 7.

Balancing individual legal services with strategic activities

The legal services and organisations I met varied significantly in the degree to which they engaged in individual legal service delivery and/or strategic activity. At one end of the spectrum, as explained further below, private law firms in England are essentially entirely focused on individual service delivery. At the other end of the spectrum, organisations such as Bazelon, the ACLU and MDAC deliberately engage solely in strategic activity.

In the US, many organisations fell somewhere in the middle of the spectrum, engaging in a variable mix of individual legal services and strategic activities. Some, such as the MHLS, remain primarily focused on individual service delivery whereas others, like DRNY, closely entwine the two. I was interested to understand how the organisations which attempt to do both activities balance the competing demands, because this is a challenge we face in MHDL.

US organisations that strike a balance

The following legal services I met conduct both individual legal services and strategic advocacy to varying degrees.

MHLS

Due to its mandate, the MHLS' work is 'very client specific and client based'.⁵⁴¹ However, notwithstanding its primary focus on individual legal services, the MHLS does tackle some systemic issues including through strategic litigation. In fact, at least in relation to certain issues, it is arguably within the MHLS' statutory mandate to pursue strategic litigation:

It's certainly part of our mandate... to litigate issues having to do with abuse and mistreatment or issues having to do with improper discharge or improper admission. All of those things are within our mandate.⁵⁴²

As explained further below, the MHLS' strategic advocacy arises out of its day-to-day work.

⁵⁴¹ Sara Rollyson.

⁵⁴² Lisa Volpe. MHLS has a statutory duty to 'initiate and take any legal action deemed necessary to safeguard the right of any patient or resident to protection from abuse or mistreatment, which may include investigation into any such allegations of abuse or mistreatment of any such patient or resident': *Mental Hygiene Law* § 47.03(e).

Lisa Volpe said that it was rare for the MHLS to get criticised for taking on systemic issues rather than just focusing on individual cases:

Very occasionally [we get criticised, but] I think everybody recognises the value of having a kind of a watchdog agency that's looking out for people where the big state agencies would not because they have other concerns, they have the entire mental health system to deal with from a financial point of view, from all the points of view of managing big agencies, so they may do things in a way that's more expeditious for them but does not necessarily protect the individuals' liberty interests or whatever the issue is in the way that we would see it. Occasionally we get criticism, sometimes out of the Attorney-General's office – 'Why are you even doing this?' – and certainly very often from the Office of Mental Health, they'll sort of be rankled by our actions, but hardly [any criticism] from the court system itself.

The Second Department MHLS has a dedicated Special Litigation and Appeals Unit; at seven lawyers, Lisa Volpe (who is the principal attorney-in-charge of that unit) described it as 'a very small group of people for a very large docket', especially as most of them do appeals and trial work rather than strategic litigation. The Second Department MHLS is by far the biggest in terms of volume. The other MHLS Departments do not have such formal special litigation units but they 'each have a couple of attorneys who are dedicated to appeals and to the extent that they do special systemic litigation'.⁵⁴³ Lisa Volpe explained that they 'have a policy in the Second Department of trying to take on almost every [case] that comes our way because we feel that we have an obligation to our clients who wouldn't otherwise have representation, but that's not always the case and it's very much to do with what each individual Department's overall docket burden is and whether they can take on a case'.

When asked what is the biggest challenge to the MHLS being able to protect its clients' rights, Lisa Volpe said, 'I guess it would be to have enough staff to cover everything that needs to be covered. It all comes down to funding'.⁵⁴⁴ While it is sufficiently resourced to represent all individuals within its mandate at their hearings, funding does limit the MHLS' ability to do systemic work: 'It's very much a question of whether we have the funds to do true systemic litigation, which is a huge undertaking, very costly'.⁵⁴⁵ Aside from actual costs, taking on complex strategic litigation also involves significant human resources, which can come at a personal cost to the staff involved:

I get paid a salary, so if I work 24 hours a day or 8 hours a day I'm not getting paid any more, it's just my time. It's the resource itself that gets stretched... When I was involved in the federal nursing home case and I was the lead attorney... I was working probably 60 hours a week minimum, for about a year.

If faced with a situation where the MHLS' funding was significantly reduced, Lisa Volpe said that she thought the MHLS would cut strategic advocacy (and, if really pushed, representing people in the community) before compromising individual legal services for compulsory inpatients because of its clear mandate:

... certainly we would not do the systemic litigation because really our mandate speaks so clearly to representing individuals who are admitted, being discharged, being treated improperly... Although we stretch it a lot, it's really very clear that our mandate speaks to the individual, so we would do that before we would do anything else.

It is evident that the statutory duty to provide a wide range of individual legal services limits the amount of strategic litigation which MHLS can take on.

Washington DC Public Defender Service Mental Health Division

Like the MHLS, the focus of the DCPDS MHD's work is individual mental health legal services. However, by limiting the number of individual matters they take on (surplus cases are allocated by the court to a panel of private bar members), they are able to spend some time tackling complex and systemic issues of strategic importance.

⁵⁴³
Lisa Volpe.

⁵⁴⁴
Ibid.

⁵⁴⁵
Ibid.

Extra work to meet demand is absorbed by the individual attorneys effectively donating their time...

– Alison Lynch, DRNY, New York

For example, managing attorney Kim Clark said that the involuntary medication statute was ‘one we flagged for a number of years as needing attention’. She explained that it had been very difficult to get the issue up into a superior court as the state would settle if it looked like a precedent was going to be set. However, the current mental health calendar judge identified it as a constitutional issue and proactively raised it in a case, and the court contracted a private firm to provide an amicus brief on the issue (which happened to have been filed on the day I visited her).

Being part of the DC Public Defender Service means that Kim Clark and her mental health team can tap into the Service’s Special Litigation Department. This also allows them to strategise and undertake cases with greater impact.

Disability Rights New York

About the US protection and advocacy system

The US federal government set up the protection and advocacy (**‘P&A’**) system in 1975 in order to provide oversight after journalists revealed scandalous conditions in disability institutions. The intention of the P&A system – and mandate of the services – is to protect individuals with disabilities from abuse and neglect and to promote their civil rights.

Initially, the system focused on P&A programs for individuals with developmental disabilities (**‘PADD’**) but other programs have been gradually added:

PADD is the first P&A program, created by the Developmental Disabilities Assistance and Bill of Rights (DD) Act of 1975. P&A agencies are required by the Act to pursue legal, administrative and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable federal and state laws. The DD Act provided for the governor of each state to designate an agency to be the P&A and to assure that the P&A was, and would remain, independent of any service provider. Most entities designated as P&As are private non-profit organi[s]ations created specifically for the purpose of conducting the P&A programs. However, some P&As are part of state government, a few are hybrid quasi-public agencies, and a few P&As reside within civil legal services programs...

The Client Assistance Program (CAP) was established by the 1984 Amendments to the Rehabilitation (Rehab) Act. Services provided by CAPs include assistance in pursuing administrative, legal and other appropriate remedies to persons receiving or seeking services from state rehabilitation agencies under the Rehab Act. A CAP agency may provide assistance and advocacy with respect to services that are directly related to employment for the client or client applicant...

The Protection and Advocacy for Individuals with Mental Illness (**‘PAIMI’**) Program was established in 1986. [PAIMI programs] are mandated to protect and advocate for the rights of people with mental illness and investigate reports of abuse and neglect in facilities that care for or treat individuals with mental illness. The Act was subsequently amended to allow [PAIMI] also to serve individuals with mental illness who reside in the community.

The Protection and Advocacy for Individual Rights (PAIR) Program was established by Congress under an amendment to the Rehabilitation Act in 1993. PAIR programs provide for services to persons with disabilities who are not eligible for services under the three previously established P&A programs (PADD, PAIMI, and CAP). With PAIR, the P&As were thus authori[s]ed to serve persons with all types of disabilities. Although PAIR is funded at a lower level than PADD and PAIMI, it represents an important component of a comprehensive system to advocate for the rights of all persons with disabilities.

The Protection & Advocacy for Assistive Technology (PAAT) Program was created in 1994 when Congress expanded the Technology-Related Assistance for Individuals with Disabilities Act (Tech Act) to include funding for P&As to assist individuals with disabilities in the acquisition, utili[s]ation, or maintenance of assistive technology devices or assistive technology services through case management, legal representation and self advocacy training.

The Protection & Advocacy for Beneficiaries of Social Security (PABSS) program was established in 1999 when the Ticket to Work and Work Incentive Improvement Act was enacted into law. Under this Act, grants to the P&A programs provide advocacy and other services to assist beneficiaries of Social Security secure or regain gainful employment.

The Protection & Advocacy for Individuals with Traumatic Brain Injury (PATBI) program was created in 2002 to provide protection and advocacy services to individuals with traumatic brain injury. Although P&As often served such individuals under PAIR, CAP, or PABSS, this grant provides more resources specifically to address the unique needs of this population.

The Protection & Advocacy for Voting Accessibility (PAVA) program was established in 2003 as part of the Help America Vote Act of 2002. Under this program, P&As have a mandate to help ensure that individuals with disabilities participate in the electoral process through voter education, training of poll officials, registration drives, and polling place accessibility surveys. P&A agencies may not use PAVA program funds for litigation. There is no such restriction in any of the other P&A programs.⁵⁴⁶

Each US state is required to appoint one or more P&A agencies, and their budgets are set based on the state population.

DRNY was designated as the P&A agency for New York State on 1 June 2013.

In contrast to the MHLS' and DCPDS MHD's primary focus on individual legal services, DRNY engages in a real mix of responsive individual legal services, proactive investigative and monitoring work and targeted strategic activity. Jennifer Monthie, director of DRNY's PADD program, described the greatest strength of the P&A model as having both an access and information-gathering mandate with a mandate and ability to then advocate for individual and systemic change:

The federal program was set up to not only protect individuals subject to abuse or neglect but then to advocate on their behalf to defend their rights. These federal programs ensure the access that DRNY needs to examine problems within the service delivery system and then to take action by advocating for change.

At time of interview, around 70-80% of DRNY's PAIMI activity was project work rather than individual legal services due to low demand but, at other times, individual services form the majority of work.⁵⁴⁷ If individual demand increased, the PAIMI program would prioritise individual requests for assistance over project work; they would not turn away an individual who fell within their priorities for assistance.⁵⁴⁸ Extra work to meet demand is absorbed by the individual attorneys effectively donating their time, not because of management demands but because they care and want to do the work.⁵⁴⁹

⁵⁴⁶ National Disability Rights Network, 'P&A/CAP Network' <<http://www.ndrn.org/about/paacap-network.html>>.

⁵⁴⁷ Alison Lynch.

⁵⁴⁸ Ibid.

⁵⁴⁹ Ibid.

While everyone who falls within their program priorities gets some level of service, DRNY deliberately directs its resources to those matters that systemically impact individuals with disabilities and are likely to bring a benefit beyond the individual.⁵⁵⁰ Resources are not specifically quarantined to enable DRNY to respond to systemic or emerging issues – ‘generally we just figure it out as we go along’⁵⁵¹ – although the more likely a case is to contribute to systemic reform, the more likely DRNY is to put more resources into it. Mark Murphy, director of DRNY’s PAIMI program, noted that DRNY ‘generally take[s] fewer cases (based on priorities) since our focus is on systemic reform of systems’. He said that DRNY chooses to provide more intensive, in-depth services to fewer people rather than stretch services to provide a lesser service to more individuals. Because the strategic work is so central to DRNY’s operations, ‘the cases on which we spend the most resources are generally chosen with great care’.⁵⁵²

MFY Legal Services, Inc.

Like DRNY, each program at MFY conducts a mix of individual legal services and strategic work, which is seen as key to MFY’s success:

MFY as a whole really does an amazing job balancing the direct work and the policy work, which I think is great. We’re not just a direct service organisation, we’re not just a policy organisation but we do both.⁵⁵³

In fact, strategic work is so important to MFY’s goals that it decided to forgo federal funding after the US Congress imposed new restrictions on organisations receiving funds from the Legal Services Corporation which prevented them from conducting class actions or lobbying.⁵⁵⁴ In 2003, MFY ‘successfully restructured itself as an independent legal services provider, able to respond to emerging legal needs with all the tools available to lawyers not subject to federal restrictions’.⁵⁵⁵ This has allowed them ‘the flexibility and freedom to be creative’⁵⁵⁶ in their impact work.

Because we’re a smaller non-profit I think we have more flexibility than some of the others, less of the bureaucracy, we’re able to jump in and quickly identify new issues.⁵⁵⁷

As well as directly helping the individuals involved, maintaining some individual service delivery is also important for generating the strategic impact cases and campaigns:

MFY I think is very strong at having a great balance between individual representation and policy and impact work. I would say [the impact work] mostly comes in from a client case and then builds up from there...

A much smaller proportion of MFY’s mental health law project work is systemic advocacy than in other MFY programs – 5-10% compared to ‘at least 50%’ – which supervising attorney Mallory Curran attributed to the project’s particular funding conditions and the requirement to report back on certain targets. She was hopeful of expanding the proportion of strategic work done by the program but described it as ‘one of our biggest challenges’ to get frontline lawyers to strike this balance in practice:

It has been harder than I anticipated figuring out how to carve out the time for people to engage in the... more systemic work because the intake is so relentless. We’ve implemented a few new things; we’ve taken on a new paralegal to help with some of the intake to free people up to do even more full representation and less of the advice. We’ve been trying to put new systems into place⁵⁵⁸ so people have more time to work on those things, because I think that people really want to...

[I]f there’s a way you can institutionalise the expectation that you are going to set aside protected time to work on these other issues, and even though it’s going to be really hard to say no to more people, individual people... I don’t know if there’s a way to set that up with the funding structure and thinking about how funders can help organisations be shaped... If the expectation from your funders is that you’re also doing the policy work and [they] understand that means fewer individual cases to report, that’s what we want. So when I’m thinking about what I am going to report about what we’ve done with our time, we’re expected to have worked on policy initiatives and [say,] ‘These are the ones we’ve worked on’.

⁵⁵⁰ Jennifer Monthie.

⁵⁵¹ Mark Murphy.

⁵⁵² Ibid.

⁵⁵³ Mallory Curran.

⁵⁵⁴ MFY withdrew from Legal Services of New York, the umbrella organisation that disbursed the Legal Services Corporation funds; Mallory Curran.

⁵⁵⁵ MFY, *Mobilising for justice since 1963* (2013) 9.

⁵⁵⁶ Mallory Curran.

⁵⁵⁷ Ibid.

⁵⁵⁸ Other strategies included ‘trying to streamline the process to get to the point where you’re not spending half an hour with someone to figure out you’re going to say no to someone, but that you’re taking five minutes to figure that out. Also thinking about online resources if you’re not able to help someone but you could send them a factsheet or link’. Mallory Curran.

... thinking about the bigger issues is an 'optional extra' and a luxury that most lawyers cannot afford.

– English lawyer John O'Donnell

One way that MFY's mental health law project works towards freeing up some resources is by educating and empowering mental health service staff and people with mental illness to engage in advocacy themselves. Mallory felt that investing time and resources in being on site at hospitals, being seen to be there and engaging with staff, really pays off in terms of people being aware of their service and understanding which referrals are appropriate. Over time, close engagement with staff can educate and empower them to advocate on those issues, reducing the need for direct legal services:

As an example, when I worked at a previous job, I was talking to a psychologist about one case for a student who had an education-related issue. The school had done something wrong and we got something called compensatory education services over the summer and then six months later [the psychologist] was like, 'I have to tell you, I just got off the phone... for this other patient and they had done [the same thing], and I told [the school], well you better give my patient compensatory education services because it's not right what you did, and they gave it to her!' That's exactly what I want to happen... I'm never going to meet that patient because [the psychologist is able to say,] 'No, I know what my patient's rights are, you can't do what you're saying you're going to do, you need to do this'.

Mallory also said it was important for people with disabilities to learn more about what their rights are and to empower them to self-advocate: 'If you're working with a patient and they start to see, "Oh, this is what I can do for myself", and the next time ideally they're calling and saying, "Oh my worker said this and then I asked to speak to their supervisor", now it's evolved for them to have a sense of self efficacy'. The International Human Rights Law Group has also stressed the importance of empowerment as both a means and an end:

Client empowerment cannot be overemphasi[s]ed as an important goal of human rights lawyering. As an empowerment tool, the lawyer is not merely a facilitator for people to achieve justice, but also transfers knowledge and skills [which] the individual can use throughout their lifetime. The empowerment approach often expands the amount of time needed to provide service to an individual, but the understanding is that in the future such services may not be needed.⁵⁵⁹

Focusing on the individual: constraints on strategic advocacy by private firms in England

In contrast to the services and organisations I met in the US, private mental health and disability law firms in England have no mandate or standing to address systemic issues. They are accordingly much more focused in terms of providing only instructions-based, individual legal services and they rarely engage in strategic law reform or campaigning.⁵⁶⁰ While they may raise issues which affect a broader group with the hospitals they attend, such as conditions of seclusion rooms, they will only do so on behalf of an individual client.⁵⁶¹ Similarly, although they do take on a range of higher court matters that may be of significant public interest and/or lead to systemic reform – including High Court judicial reviews, County or High Court damages claims (for torts such as negligence and unlawful imprisonment) and actions for breach of the *Human Rights Act 1998* (UK) – the public interest value of the work is incidental to the individual client's case rather than the driving motive.

Aside from the lack of formal mandate, the individual client focus of private firms is driven by the funding model. As Legal Aid Agency funding is tied to specific legal activities for individual clients, private practitioners receive no remuneration – and thus, apart from a small cohort of passionate, dedicated lawyers, have no incentive – to consider and creatively address systemic issues.⁵⁶² Accordingly, thinking about the bigger issues is an 'optional extra' and a luxury that most lawyers cannot afford.⁵⁶³

⁵⁵⁹ Wilson and Rasmussen, above n 498, 45.

⁵⁶⁰ Tam Gill, John O'Donnell.

⁵⁶¹ Tam Gill.

⁵⁶² Jonathan Wilson, Tam Gill, John O'Donnell.

⁵⁶³ John O'Donnell.

‘... I don’t think you can underestimate the value of the systemic litigation for really keeping the big agencies honest and reminding them where their focus is meant to be.’

– Lisa Volpe, MHLS, New York

While many lawyers do have a vision for what they want to achieve – ‘we come to this with a sense of justice and a desire to achieve equality before the law’⁵⁶⁴ – their ability to achieve it also depends on what cases walk in the door. As there are over 300 firms with contracts to provide mental health legal services in England, there are many potential doorsteps on which strategic issues (and the right vehicle to pursue those issues) may land and many of those 300 firms would not be interested in taking on such issues. Accordingly, being able to run a significant case has an element of ‘being in the right place at the right time’.

Furthermore, working often in small and very busy practices means it is hard to develop the skills and experience to conduct creative and complex litigation with a strategic intent; it is simply not possible to drop or hand over all other commitments when a potentially significant but resource-intensive case comes along. For example, Tam Gill acknowledged the limits of her service, telling me that she does not have the expertise or time to conduct matters before the ECtHR. However, she has referred clients to others to take on such cases (and had one client before the ECtHR at the time I met her).

Nevertheless, Emma Norton, a lawyer working at Liberty (the National Council for Civil Liberties in the UK), noted that strategic litigation arises from the ‘bread and butter work’ done by private lawyers, who she said are really good at picking up policy issues. Furthermore, she said it is important that services continue to provide on-the-ground advocacy and conduct ‘first instance’ (lower level) casework because, if the volume of this work drops, it will have a detrimental, flow-on effect on strategic advocacy. She noted this is what happened in relation to prison work in England: in the 1990s and early 2000s, many important prisoner rights cases were run but, since the Legal Aid Agency stopped funding prison advice, the strategic work has dried up.

Reflections

In reflecting on the balance between individual and strategic work, the people I spoke to in different settings expressed a range of views.

Michael Perlin felt that the best legal services were ones that did a mix of individual and strategic advocacy. Tina Minkowitz also thought that such a mix would be very effective:

It could be a great strength of a legal service that does advocacy for individuals to also use strategic litigation and UN complaints that grow out of individual cases, and to use your knowledge and experience with individual cases to inform advocacy for legislative reform (both to be aware of loopholes that should be closed, and to speak credibly about how abusive the system is).

For many organisations I met, their statutory mandate, funding conditions or organisational philosophy were quite decisive in determining their work mix – either restricting them to one form of work or the other, or clearly guiding how they should prioritise between individuals services and strategic activity. These factors may be non-negotiable and are often hard for the organisation to control although, as MFY demonstrated by deciding to forgo federal funding, sometimes tough decisions can be made in order to pursue what the organisation believes is the best course of action for achieving change.

⁵⁶⁴
Richard Charlton.

Where an organisation does have greater control but nevertheless finite resources, it can be hard to determine how best to strike the balance between individual and strategic advocacy. For the organisations I met that did both, knowing they are not the only legal service assisting individuals allows them to quarantine some resources to tackle the bigger issues. However, the decision to engage in strategic advocacy is far more challenging if the cost of that decision is turning away individuals seeking help (including people in detention) when there are insufficient alternative legal services to assist them and significant unmet need. This is the situation with which MHDL is grappling.

I asked Lisa Volpe whether, if the MHLS did not have such a clear statutory mandate, she would choose to retain some strategic work at the expense of individual legal services if their funding was cut. She still leaned towards individual legal services but recognised the value of both activities for this client group:

I think the individual representations is probably the more important because it truly is the day-to-day, nuts and bolts of what an individual who's been confined or who's been subject to guardianship, who doesn't want to be or who's been treated badly... those are the day-to-day issues for which people need immediate relief and that's what we do and do best, but I don't think you can underestimate the value of the systemic litigation for really keeping the big agencies honest and reminding them where their focus is meant to be.

While Tina Minkowitz thought both activities were important, she felt that a specialist legal service needs to conduct at least some strategic advocacy and encouraged exploration of alternative and lay advocates to supplement existing legal services:

Individuals facing the state and quasi-state entities need to have advocacy support including legal support, I would not want to take this away from anyone. But it should not be a question of taking away, rather adding....

I think there needs to be some energy and attention devoted to systemic work, and perhaps have a system to assess the needs of individuals – not the “merit” of their cases – and maybe find alternatives like pro bono, lay advocates or paralegals who could be trained to help those that you can't help directly.

When deciding how to balance unmet legal need with a desire to pursue systemic change, MDAC's litigation director Ann Campbell advised first mentally divorcing the unmet need from the strategic goals; work out what is the change you want to see, as only once this is determined can you work out the best strategy. Despite the dearth of legal representation in Hungary and surrounding countries, and the significant demand on her for individual legal services, Budapest lawyer Dr Adrienn Gazsi saw the value in MDAC's limited focus on purely strategic advocacy; she felt that having someone focusing on the system is essential where the system itself is so poor.

Following a series of regional conferences to explore the strategic methods and practices employed by legal services to promote and support democracy, human rights and access to justice, the International Human Rights Law Group provided some advice on this issue as well:

In a push to expand services... human rights lawyering organi[s]ations may dilute the quality of individual services and hamper the overall effectiveness of the organi[s]ation. Alternatively, a failure to reach all or most of the constituency may severely limit the benefits of the organi[s]ation. The tension between quantity and quality of services was almost universal [in the conferences] and often influenced or informed the development of the case intake strategies. Strategic goals beyond individual representation helped ensure quality representation and created, where politically possible, broader impact.⁵⁶⁵

They concluded that '[o]rgani[s]ations that are able to identify critical cases and expend sufficient resources to pursue them are often more effective than general service organi[s]ations that try to meet the needs of all citizens'.⁵⁶⁶

⁵⁶⁵ Wilson and Rasmussen, above n 498, 48.

⁵⁶⁶ Ibid 104.

Planning and priority-setting for strategic advocacy

The most effective human rights lawyering organi[s]ations have a clearly stated objective or set of objectives, and have appropriate strategies to achieve them. The most successful... organi[s]ations think structurally and organi[s]ationally when setting their objectives, assessing where the greatest impact can be achieved with limited resources.⁵⁶⁷

The extent to which the organisations I met were able to plan and set priorities for their strategic advocacy varied considerably. Quite a number of the organisations were bound to a degree in their priority-setting by external funders, mandates or other constraints on their activity. Also, many people noted that strategic advocacy often arises from unplanned or unpredictable opportunities and it is important to have sufficient flexibility to be able to capitalise on those moments when they present rather than be limited by a pre-existing plan. Despite these challenges, most organisations regularly and consciously plan and set priorities for their strategic activity in order to focus their limited resources for maximum effect.

For example, at DRNY, '[p]riorities are very important given the demand for services and [so] are consciously set'.⁵⁶⁸ Jennifer Monthie explained:

Each federal [P&A] program has priorities, some are set by statute and others are set by incorporating a period of public comment which are ultimately reviewed by DRNY's Board of Directors for approval. The program priorities for the PADD and PAIMI programs also incorporate the input from the PADD and PAIMI Advisory Council...

For those programs where DRNY has the ability to set priorities, DRNY uses its vast experience serving New Yorkers with disabilities to propose language for priorities, seek public comment, Advisory Council assistance, comment from other organi[s]ations and other federal partners that serve individuals in New York State, and its board to develop these priorities.⁵⁶⁹

DRNY's PAIMI program priorities for October 2014-September 2015

1. Advocate to protect people in facilities (as defined in the PAIMI statute and regulations) from abuse and neglect.
2. Advocate to reduce the use of seclusion and restraint in facilities, including monitoring the use of seclusion and restraint in facilities to ensure that any use is consistent with legal requirements.
3. Advocate to ensure that people receive necessary supports and services in the most integrated setting appropriate.
4. Advocate to ensure that people are free from discrimination in housing, employment, education, access to public benefits and services, and access to public accommodations.
5. Advocate to ensure that public school students receive appropriate supports and services in the least restrictive environment, including those necessary to remain in school, be free from bullying, and not subject to seclusion and restraint.
6. Advocate to ensure that people have access to publicly funded mental health services, including ensuring access to all appropriate managed care and waiver services and enforcing rights secured by mental health parity laws.
7. Advocate to ensure that people in prisons and jails receive appropriate mental health services in the least restrictive environment, including reducing and eliminating solitary confinement for individuals with mental illness and assuring that appropriate discharge planning is provided for individuals returning to the community.
8. Advocate to address systemic failures to implement appropriate crisis intervention services and mental health and suicide prevention screenings, assure appropriate interactions in the community between persons with mental illness and law enforcement personnel, and increase training on mental illness and crisis intervention techniques for law enforcement personnel, including police officers and staff in prisons and jails.

⁵⁶⁷
Ibid 5.

⁵⁶⁸
Mark Murphy.

⁵⁶⁹
Jennifer Monthie.

9. Advocate to ensure that people make their own decisions and control their resources to the maximum extent possible.
10. Conduct outreach, education and training to assure that persons with mental illness, family members, advocacy organi[s]ations, and providers have an increased understanding of the legal rights of persons with mental illness and know about DRNY and the services it provides.

Mark Murphy explained that external factors – ‘especially funding or lack thereof’ – do play a large role in the priority-setting process:

Obviously, if you do not have the resources, you cannot take on more issues... We [also] consider what other groups are doing; the federal law authori[s]ing our work requires us not to duplicate work being done by others to the extent possible.⁵⁷⁰

The priorities are generally in effect for three years, although each year they are reviewed by the staff to see if any changes may be necessary given intervening events; if so, the Board then makes a decision to change or not change them.⁵⁷¹ The priorities are used on a daily basis to guide which cases DRNY takes on and which clients they represent.⁵⁷²

Similarly, MFY engages in priority-setting very consciously. It has an annual or semi-annual staff retreat to allow for reflection, evaluation, re-evaluation of priorities and to formalise plans for action.⁵⁷³

Unlike some other organisations which are required to do so in order to obtain funding, the MHLS does not proactively plan its strategic litigation or set an agenda of priorities.⁵⁷⁴ Instead, priorities for action arise out of its day-to-day work. Due to its high volume of individual legal services, the MHLS is well-placed to identify trends and systemic issues requiring a strategic response. Lisa Volpe provided the following example:

[The nursing home litigation – see box ‘Monitoring the settlement in *Joseph S v Hogan*: New York’ below] was born out of a realisation that the hospitals were shipping people out in very large numbers to nursing homes and essentially giving them probably less treatment and, because they were no longer in the psychiatric hospitals and nursing homes are not regulated under the Office of Mental Health, they weren’t even receiving their periodic review and they were locked up. That’s the kind of [systemic issue we notice]. So we saw that beginning to be an issue, we started to do the research on it and over time we decided we had to bring the litigation. Equally so, when it became clear that this was not only in New York but people were being shipped out to New Jersey, we got other organisations involved and it became a very large, state-wide systemic litigation.⁵⁷⁵

Once it has identified an issue, the MHLS is then able to use its statutory powers to investigate and pursue it:

Part of our statutory mandate is we can ask for any kind of documentation from the hospitals we want, so what we asked for was documentation of their discharges to nursing homes from the inpatient facilities over a certain period of time, and from that we had all the names of potential clients.⁵⁷⁶

If an individual raises an issue like this, the MHLS will pursue it on the individual’s behalf but such issues have also ‘been the source of much of our systemic litigation’.⁵⁷⁷

In contrast, Bazelon staff make plans at the start of each presidential term and direct their resources into areas where they think they will be most likely to advance their agenda. They ‘don’t do things that other people could do’ or that would clearly win;⁵⁷⁸ they leave this to others. In terms of specific litigation however, legal director Ira Burnim said that it is essentially opportunistic (see ‘Strategic litigation in the US’ below).

ACLU lobbyist Jennifer Bellamy, who has disability rights within her portfolio, described how planning is very important to their success: you need to come up with a strategy and document it. The ACLU has quite broad, long-term goals but also looks for opportunities in the short-term. For instance, when President Obama commenced his second term, the ACLU provided him with a report and checklist of things he could change administratively without Capitol’s involvement.⁵⁷⁹

⁵⁷⁰ Mark Murphy.

⁵⁷¹ Ibid.

⁵⁷² Ibid.

⁵⁷³ Jota Borgmann.

⁵⁷⁴ Lisa Volpe.

⁵⁷⁵ Ibid.

⁵⁷⁶ Ibid.

⁵⁷⁷ Ibid.

⁵⁷⁸ Ira Burnim.

⁵⁷⁹ Jennifer Bellamy.

MDAC developed a strategic framework for 2014 to 2019, which is their first long term strategy.⁵⁸⁰ It outlines three campaign areas (legal capacity, the right to live independently and be included in the community). Each campaign area comprises three common strategic goals, each of which is supported by three strategies:

MDAC's strategic goals	Identified strategies
Securing justice	Developing ground-breaking case-law Seeking remedies for individuals Activating the legal community
Promoting inclusion	Monitoring human rights Holding States to account Developing and advocating policy options
Mobilising solidarity	Putting a face to the case Shaping public opinion Building a global community of supporters

The plan gives MDAC greater focus and clarity in determining how to expend its limited resources. This is important because MDAC's biggest challenge is sufficient, reliable funding to be able to implement its ideas. Since its peak in around 2011-2012, MDAC's budget and consequently staffing have shrunk following changes in the European financial situation and donors either ceasing operation or ceasing to fund disability work. Its initial and biggest funder, the Open Societies Foundation, is also looking to reduce funding to MDAC over the coming years because its focus is on providing start-up support rather than ongoing core funding.⁵⁸¹

Operating at a global level from a small office in Budapest, with only a small number of staff, presents challenges and necessarily dilutes the level of focus that MDAC can apply to any one country. However, MDAC feels that transcending a limited geographical area is important for their cause notwithstanding their limited resources. Campaigns director Steven Allen said that operating in multiple jurisdictions, and being able to draw on the experiences of all of them, gives them greater credibility and changes the level of impact they can create. It also makes them unique: no other global organisation is doing the same type of litigation they do. It does however mean they need to be more focused in what issues they take on to achieve some narrative consistency to their work. They receive numerous requests for assistance from around the world to which they say no.

Aside from the overall quantum, funding conditions also influence the work which MDAC can undertake. Some funding comes with particular restrictions or is tied to particular projects or types of cases (for instance, they receive some funding to conduct cases against torture but this funding generally does not extend to cases of ill-treatment).

Involvement of consumers, service users and those with lived experience

There was considerable variation in the extent to which the organisations I met actively consulted with and sought the involvement of service users and people with lived experience of the issues at hand when planning and prioritising for strategic advocacy. Many, like the MHLS,⁵⁸² have only limited input from consumers and NGOs representing people with disabilities.

Steven Allen acknowledged that MDAC only involves its beneficiaries in a limited way in its governance. While some Board members have lived experience of psychiatry, none have direct experience of institutionalisation. Steven described the challenge of trying to involve people with mental disabilities, especially when operating on a global scale, and feared any efforts would simply be tokenistic. He felt that, as a specialist legal advocacy organisation, direct consumer input is less important for guiding the litigation work but that it is important in campaigning. For that reason, MDAC collaborates with disabled people's organisations but does not itself pretend to be representative of people with mental disabilities.

⁵⁸⁰
Steven Allen.

⁵⁸¹
Ibid.

⁵⁸²
Lisa Volpe.

In contrast, service users and people with lived experience play an important role in shaping DRNY's work. The PAIMI program is supported by the PAIMI Advisory Council, where the majority of members 'must be individuals with mental illness'.⁵⁸³ The primary role of the council is to make recommendations to DRNY about the priorities of the PAIMI program and to discuss the issues and problems individuals with mental illness face in New York.⁵⁸⁴ The chair of the PAIMI Advisory Council is also a member of DRNY's governing board.⁵⁸⁵ Similarly, the majority of members of the advisory council for the PADD program 'must be individuals with developmental and intellectual disabilities who are eligible for services, or have received or are receiving services or parents or family members, (including those representing individuals with developmental and intellectual disabilities who live in institutions and home and community based settings), guardians, advocates, or authori[s]ed representatives of such individuals'.⁵⁸⁶ Mark Murphy also said that DRNY 'definitely tr[ies] to cultivate relationships with groups of people with disabilities and family members, and [that] such relationships are important because they are a source of information, issues, and clients'.

Strategic litigation

Many strategic advocacy organisations I spoke with used litigation as a strategic tool. Litigation simply involves bringing a legal issue before a court for resolution. Even if the case is run on behalf of individual litigant, litigation can have a systemic impact when the court is persuaded to:

- Recognise a new right or apply an existing right in a new context;
- Overturn an accepted interpretation of the law to be more human rights-compatible; or
- Declare an existing law or practice unlawful and/or inconsistent with rights.

Such decisions result in laws, policies and practices being changed for the benefit of all people otherwise affected by them, not just the individual litigant. Litigation is strategic when it is conducted with this broader goal in mind.

Many people I spoke with in both the US and England described how important strategic litigation has been in advancing the rights of people with disabilities. However, strategic litigation is challenging because, depending on the scale of the action, it can be slow and resource-intensive and success is not guaranteed.

Strategic litigation in the US

Strategic litigation and high-impact cases in the US typically relate to due process rights under the Constitution and/or the ADA,⁵⁸⁷ as 'this is what the courts will listen to'.⁵⁸⁸ Ira Burnim, who has been Bazelon's legal director since 1989, said that originally and for several decades, constitutional cases were the most significant and influential type of strategic litigation. However, Ira said it was harder to win constitutional cases now (though the Supreme Court's judgment on marriage equality in *Obergefell v Hodges* just a month after I left the US shows the Constitution is still powerful). Ira said that statutory cases have now moved to the forefront, including cases under the ADA, the *Individuals with Disabilities Education Act* and the *Medicaid Act* (Medicaid is the US health care program for low income individuals). Other matters which are regularly litigated are *Olmstead* issues (see box 'The *Olmstead* decision' in Part 4B above) and issues arising under the federal *Civil Rights of Institutionalized Persons Act*.⁵⁸⁹ There is also a general cause of action in the US which can be used for any 'deprivation of rights'.⁵⁹⁰ The cases are often run as class actions, although Ira Burnim said that Bazelon will also run individual cases to highlight a particular issue.

Summaries of some of Bazelon's impressive strategic litigation successes are available online.⁵⁹¹ Ira said that Bazelon's litigation is essentially opportunistic, however it does involve careful planning and strategising. He said one of the good things about working at Bazelon is that there is time for reflection and discussion, which is essential for good work. Ira said you have to have a vision of what you want to achieve, rather than just jump into litigation when you see a bad situation, otherwise you can make the situation worse. He noted that there are some issues they want to keep out of the Court of Appeal for now. He was somewhat pessimistic about the state of affairs, noting that laws are getting worse and the courts are getting more conservative.

⁵⁸³ DRNY, 'PAIMI Advisory Council' <<http://www.drny.org/paimi-advisory-council.html>>.

⁵⁸⁴ Ibid.

⁵⁸⁵ In the 2014 fiscal year, which was the first year that DRNY was designated as the P&A for New York, two of the nine DRNY governing board members were people with mental illness who are recipients/former recipients of mental health services or who have been eligible for such services, one was a family member, three were advocates or authorised representatives and three were 'other persons who broadly represent or are knowledgeable about the needs of the clients served by the P&A system': DRNY, *PAIMI Program - Annual program performance report - New York - 2014 Fiscal Year*, 2.

⁵⁸⁶ DRNY, 'PADD Advisory Council' <<http://www.drny.org/padd-advisory-council.html>>.

⁵⁸⁷ Mark Murphy, Ira Burnim, Lisa Volpe, Alison Lynch.

⁵⁸⁸ Alison Lynch.

⁵⁸⁹ Lisa Volpe.

⁵⁹⁰ 'Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable': 42 US Code § 1983. For example, *Hirschfeld vs New York City Health and Hospitals Corporation* No. 07-CV-1819 was run on this provision (see box in text below). However, Michael Perlin noted that there are a 'host of federal jurisprudential doctrines that limit [the] availability' of these actions.

⁵⁹¹ See Bazelon, 'Our history - an overview' <<http://www.bazelon.org/Who-We-Are/History.aspx>>.

... you have to have a vision of what you want to achieve, rather than just jump into litigation when you see a bad situation, otherwise you can make the situation worse.

– Ira Burnim, Bazelon, Washington DC

Even with his decades of experience, Ira said it is still unpredictable which cases will win; ‘the stars have to align’. In his experience, it is easier to win cases where the state is already doing what you want for some people and you are just asking them to expand the program, rather than arguing to create something entirely new. Where a case is not going well, Bazelon may advise settling to avoid a loss and withdraw some of its resources from it, but would never abandon a case simply because it no longer has strategic value:

We would not... terminate our representation if the case was no longer strategic or was not advancing our mission. We might put less effort into such a case and do only adequate, rather than excellent, legal work. We might also try to persuade a firm or other organi[s]ation to take the case if there was the possibility of recovering a fee. But we would not drop the client, depriving the client of legal representation, especially after the client chose/agreed to bring a case that we once thought was or would be strategic.⁵⁹²

DRNY regularly engages in strategic litigation, examining not just the fair application of laws but ensuring that gaps in rights protection and laws which are discriminatory on their face are also addressed.⁵⁹³ Sometimes the areas of concern are brought to their attention by individuals contacting DRNY and other times it is through complaints in public media or through their interaction with individuals in the community.⁵⁹⁴ DRNY is also proactive in identifying issues that impact many individuals with disabilities. It has a robust monitoring responsibility and this monitoring exposes systemic concerns.⁵⁹⁵ High impact cases are usually carefully planned and constructed rather than opportunistic: ‘We are generally aware of the key issues and then go about setting up the best way to address them, but occasionally an unknown important issue comes to us’.⁵⁹⁶

As noted above, the MHLS is under a statutory duty to ‘initiate and take any legal action deemed necessary to safeguard the right of any patient or resident to protection from abuse or mistreatment, which may include investigation into any such allegations of abuse or mistreatment of any such patient or resident’.⁵⁹⁷ While the MHLS has litigated an impressive number of cases against hospitals where it provides services to improve conditions on behalf of their clients,⁵⁹⁸ Lisa Volpe explained that ‘if we can resolve something without going to court we always try to do that because it’s the path of least resistance’.

For many years, P&A organisations were considered to have representational or associational standing to commence litigation in their own name on behalf of a general class of people they assist (rather than having to litigate on behalf of a specific client).⁵⁹⁹ However, in 2012, the New York Court of Appeals for the Second Circuit set aside a favourable decision on the basis that the P&A plaintiff did not have standing to bring the case.⁶⁰⁰ A separate but similar judgment was made in relation to the MHLS in 2015.⁶⁰¹ These rulings have made strategic litigation more difficult. The organisations must now bring litigation in the name of specific clients, which can be problematic because clients’ circumstances can change frequently (for instance, they may be discharged from hospital), rendering their claim moot, so a class action with multiple plaintiffs is required to keep the case on foot.⁶⁰²

Lycette Nelson, who has litigated in both the US and Europe, noted some benefits to litigating in the US, where she felt it is on the whole easier to achieve widespread structural reform for people with disabilities through litigation than in Europe. For example, she said that years of litigation under the ADA has resulted in a much more developed legal analysis of ‘reasonable accommodations’⁶⁰³ in the US than in Europe.

⁵⁹² Ira Burnim.

⁵⁹³ Jennifer Monthie.

⁵⁹⁴ Ibid.

⁵⁹⁵ Ibid.

⁵⁹⁶ Mark Murphy.

⁵⁹⁷ *Mental Hygiene Law* § 47.03(e).

⁵⁹⁸ See summary in ‘History of the Mental Hygiene Legal Service’, above n 23.

⁵⁹⁹ Lisa Volpe.

⁶⁰⁰ *Disability Advocates Inc. v New York Coalition for Quality Assisted Living Inc* 675 F3d 149 (2nd Cir, 2012). Disability Advocates Inc was the P&A for New York State at the time. See Bazelon, ‘Adult home residents suffer a setback’ <<http://www.bazelon.org/News-Publications/Press-Releases/4-6-12-Second-Circuit-Vacates-DAL-Judgment.aspx>>. The substantive case was successfully resurrected as *O’Toole v Cuomo* (see box in text below).

⁶⁰¹ *Mental Hygiene Legal Service v. Cuomo*, 14-1421-cv (2nd Cir, 2015).

⁶⁰² Lisa Volpe.

⁶⁰³ ‘Reasonable accommodation’ is defined in article 2 of the CRPD as ‘necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms’. Denial of reasonable accommodations constitutes discrimination on the basis of disability. The term is also used in the ADA.

Challenging placements in adult homes: *O'Toole v Cuomo*⁶⁰⁴

In July 2013, adult home residents in New York City reached a landmark settlement with New York State.

The settlement follow[ed] nearly a decade of litigation in a related case, *Disability Advocates, Inc. v. Paterson*[, which was eventually dismissed because the P&A bringing it was found to lack standing]. The new case, *O'Toole v. Cuomo*, was brought by residents of three adult homes on behalf of approximately 4,000 residents citywide. The plaintiffs alleged that New York State unnecessarily segregates people with mental illness in adult homes in violation of the [ADA]. “This case puts a face on people with mental illnesses and our struggle to be integrated back into the community at large,” said Plaintiff Steven Farrell, a resident of Oceanview Manor Home for Adults in Brooklyn.⁶⁰⁵

MFY represented the adult home residents with co-counsel from DRNY, Bazelon, New York Lawyers for the Public Interest and the Urban Justice Center and pro bono counsel from Paul, Weiss, Rifkind, Wharton & Garrison, LLP.

The settlement means that thousands of people who had been warehoused in 23 large adult homes will have the opportunity to live in their own homes with the services they need to succeed and be part of their communities:

Under the agreement, the state will provide as many scattered-site, supported housing units as necessary to afford all adult home residents with serious mental illnesses the opportunity to live in the most integrated setting appropriate to their needs, and will provide and maintain community services and supports including but not limited to:

- Care coordination
- Psychiatric rehabilitation services
- Employment services
- Assistance with taking medication
- Home health care
- Personal assistance services
- Assertive community treatment
- Crisis services.⁶⁰⁶

“Many adult home residents are excited about finally having the opportunity to move out of adult homes and have more freedom and choice in their day-to-day lives. “I’m thrilled about this settlement,” said Plaintiff Ilona Spiegel. “At my adult home, they don’t do anything to inspire you or encourage you to move forward. I know how to take care of myself. I want to work my way back to independence.”⁶⁰⁷

Implementation of the settlement agreement is monitored by independent reviewers, who report annually to the court.⁶⁰⁸ Although the settlement was reached over two years ago, the practical implementation of it is still in its early stages:

It is off to a very slow start. The State has acknowledged that care planning and case management services for class members are inadequate, so it is implementing a new case management program called “Adult Home Plus.” The court and counsel for the class will soon evaluate the impact of these changes on the pace of implementation and quality outcomes for class members.⁶⁰⁹

There has also been a change to the regulations about discharge from hospital, which should prevent this practice occurring in future:

The State Office of Mental Health decided that housing large numbers of people with serious mental illness in adult homes is “not conducive to the recovery or rehabilitation of the residents.” It issued a regulation prohibiting all OMH-licensed psychiatric hospitals and units from discharging patients to a “transitional adult home” – a large adult home where at least 25% of the residents have a serious mental illness – unless that is where the patient lived prior to hospitali[s]ation.⁶¹⁰

⁶⁰⁴

13-04166. For documents relating to the case, see <[http://www.bazelon.org/In-Court/Current-Litigation/OToole-v.-Cuomo-\(was-Disability-Advocates-Inc.\)/Resources.aspx](http://www.bazelon.org/In-Court/Current-Litigation/OToole-v.-Cuomo-(was-Disability-Advocates-Inc.)/Resources.aspx)>.

⁶⁰⁵

Jota Borgmann, ‘Landmark settlement for New York City adult home residents’, post on *City Voices* blog (10 December 2013) <<http://newyorkcityvoices.blogspot.com.au/2013/12/landmark-settlement-for-new-york-city.html>>.

⁶⁰⁶

Bazelon, ‘Court-approved settlement gives NY adult home residents their lives back’ (18 March 2014) <<http://www.bazelon.org/News-Publications/Press-Releases/3.18.14-OToole-v.-Cuomo-Press-Release.aspx>>.

⁶⁰⁷

Borgmann, above n 605.

⁶⁰⁸

The annual report filed on 30 March 2015 is available at <<http://www.bazelon.org/LinkClick.aspx?fileticket=4mc0Jw5IX68%3d&tabid=184>>.

⁶⁰⁹

Jota Borgmann.

⁶¹⁰

Ibid.

Role of barristers and NGOs in driving strategic litigation in England

Barristers and NGOs have played a significant role in driving disability-related strategic litigation over the last four decades in England. In the 1950s, there were around 160,000 people detained under mental health laws; psychiatry was seen as progressive and the law as ‘old hat’, which led to the removal of controls on psychiatrists under the *Mental Health Act 1959* (UK).⁶¹¹ Professor Geneva Richardson stated that subsequent progress towards respect for human rights in mental health and disability treatment in England occurred through litigation. In the 1970s and 1980s, MIND (an NGO, then called the National Association of Mental Health) had a litigation branch run by Larry Gostin, a US litigator now back working in the US, and they funded and ran significant civil rights litigation inspired by similar actions in the US.⁶¹² A number of specialist, private firms also pursued novel cases to push the law forward. It was this litigation that led to the development of the 1983 MHA, with its much stronger protections for patients.⁶¹³ As the MHA has been in its current form for quite some time, most of the disability-related test cases and strategic litigation now relates to the newer MCA and in particular the operation of the DOLS scheme.

Barristers play a central role in developing human rights jurisprudence in England as an expert is needed to pick up points and to strategise difficult cases. Numerous barristers’ chambers have specific mental health and Court of Protection teams.⁶¹⁴ For example, Aswini Weeraratne QC heads a team of four or five barristers specialising in mental health law at Doughty St Chambers. Peter Edwards noted that the complex issues arising under the MCA are being driven and led by barristers rather than solicitors. For instance, Peter said that a barrister who was interested in a particular issue approached him to see if his firm had any cases that would make a suitable vehicle to clarify the law. Peter felt that barristers operate on an academic plane and that discussions with barristers about appeals and strategy are helpful. Indeed, a number of active barristers I met are university academics as well (there is a ‘very rich academic community’ throughout the UK who focus on mental health and disability issues⁶¹⁵). Many barristers practising in this area also do a lot of training, campaigning, commenting on draft bills and submission-writing.

Following legal aid cuts (which have reduced the opportunities for private firms to get involved: see ‘Judicial review and other direct legal challenges’ in Part 3C above), barristers are now looking more to NGOs to support strategic litigation.⁶¹⁶ Liberty’s Emma Norton described how NGOs add value to cases. Some NGOs such as Liberty and MIND have their own litigation departments and run their own cases on behalf of individuals where the case is likely to have a broader impact. They are also regularly approached by private lawyers to intervene in cases, particularly at the higher levels, to provide principled statements of law and demonstrate the systemic nature of the issue. Liberty keeps an eye on what cases are coming up through the courts to consider whether to intervene (usually not until a matter reaches the Court of Appeal). She noted that the government is trying to restrict interventions by organisations like hers by requiring that the intervener must have ‘added value’ to the case or otherwise they risk having to pay the costs of the other parties in responding to their intervention.⁶¹⁷ This may well have a chilling effect on their ability to participate in the future.

MDAC’s approach to strategic litigation

MDAC identifies itself primarily as a strategic litigation organisation. As partial progress is achieved and some governments are starting to work towards implementation of CRPD rights, MDAC now has to consider when and where to keep pushing issues like full deinstitutionalisation and the complete abolition of guardianship, and whether a continued attack might result in a rollback of nascent progress.⁶¹⁸

The majority of cases MDAC takes are representative examples of widespread human rights violations rather than the worst possible examples. While they may not provide the shock factor the media often wants (although, from a perspective outside of central and Eastern Europe, some of the cases are certainly shocking), this prevents the case being dismissed as an isolated example and allows messaging to focus on the thousands of other people in the same position, creating a stronger push for systemic change.⁶¹⁹

⁶¹¹ Lucy Series.

⁶¹² Geneva Richardson.

⁶¹³ Lucy Series.

⁶¹⁴ Eg eg 39 Essex Chambers, see <<http://www.39essex.com/practice-area/administrative-and-public-barristers/mental-health-law/>> and Doughty St Chambers, see <<http://www.doughtystreet.co.uk/civil-expertise/mental-health-and-court-of-protection>>.

⁶¹⁵ Lucy Series.

⁶¹⁶ Aswini Weeraratne QC.

⁶¹⁷ Section 87 of the *Criminal Justice and Courts Act 2015* (UK) creates a presumption that third party interveners will generally not recover their own costs except in exceptional circumstances and creates a new duty on the court to award costs against the intervener in cases where any one of the following conditions are satisfied:

- (a) ‘the intervener has acted, in substance, as the sole or principal applicant, defendant, appellant or respondent;
- (b) ‘the intervener’s evidence and representations, taken as a whole, have not been of significant assistance to the court;
- (c) ‘a significant part of the intervener’s evidence and representations relates to matters that it is not necessary for the court to consider in order to resolve the issues that are the subject of the stage in the proceedings; or
- (d) ‘the intervener has behaved unreasonably’.

The duty will be set aside in ‘exceptional circumstances’.

⁶¹⁸ Steven Allen.

⁶¹⁹ Ibid.

Use of international human rights law in domestic litigation

The particular domestic legal framework, along with the varying receptiveness of domestic courts (and lawyers) to regional or international human rights law, influences whether lawyers seek to invoke international human rights law and principles in their domestic strategic litigation.

For example, the US has shown itself very reluctant to submit to the jurisdiction of international authorities and human rights instruments. Mark Murphy said that 'US courts generally will not recogni[s]e international law, although this is a growing topic of interest at the moment'. Instead, the rights considered by the US courts are those that are protected under state and federal laws so, accordingly, strategic litigation in the US focuses squarely on domestic laws and causes of action.

In contrast, the ECHR is directly incorporated into English law through the *Human Rights Act 1998* (UK). This means that breaches of those rights can be directly litigated in English courts and are subject to the ultimate oversight of the ECtHR. Furthermore, ECtHR jurisprudence from mental health and disability cases against England and other European countries have been a driving factor for domestic laws and cases in England: 'it gives us a shove'.⁶²⁰ Dr Lucy Series reported that:

Domestic courts, perhaps especially the Court of Protection (established by the MCA) make reference to the ECHR rights all the time. It is a very well embedded discourse. Whether it is always correctly interpreted is another matter, but certainly most cases will make some reference to Articles 5 and 8 ECHR, and sometimes other rights. Having said that, some cases make only limited references to human rights - for example, one shocking case involved the removal of a young man from his home and family and authorised his detention in hospital for up to two years to undergo a controversial behavioural intervention, and gave absolutely no analysis to the proportionality and necessity of the measure (*ML's case*⁶²¹).

While the ECHR has traction, the CRPD has so far had only a limited impact on the development of English jurisprudence, especially as there is no way to directly litigate it. Dr Lucy Series reported:

In terms of the CRPD, aside from a few exceptions, there is massive resistance to the CRPD within the legal community. Increasing numbers of legal academics are coming around to taking it more seriously, and a handful of practising lawyers are, but generally the legal establishment takes the view either that the CRPD has basically the same normative content as the ECHR, or (if they've come across contrary views) they think it's ridiculous and should be resisted and disregarded. I think lawyers find it especially challenging because they pride themselves on being human rights defenders, and then along comes this treaty which says that they're not... And trying to get your head around it involves a lot of reading and careful thought and discussion, and really they're not interested in doing that - so it's summarily dismissed on the basis that it is 'ridiculous', 'impractical', or else they bring out the classic objections 'what about a person in a coma?', 'what about a person who thinks they can fly and they're about to jump off a building?', 'what about undue influence?' etc etc. It's very, very, hard work trying to get people to give it a chance. On the whole, though, I've found social care professionals are quite receptive to new ideas, and you can see that some ideas from the CRPD - including independent living and supported decision making - have started to leach into social care law.⁶²²

In terms of the courts - a handful of cases reference the CRPD, but normally in ways that completely miss the point. For example, one case cited the right to habilitation and rehabilitation as grounds for sterilising a young man with learning disabilities against his wishes (*DE's case*⁶²³). In another forced sterilisation case, a really shocking one, the [Court of Protection] refused to consider the CRPD (*DD's case*⁶²⁴). Having said that, some judges are interested in the CRPD - Denzil Lush, the master of the Court of Protection, has written about it enthusiastically and has cited it in some quite progressive ways in some judgments (*OPG v Marvin*,⁶²⁵ *LB Haringey v CM*⁶²⁶).

⁶²⁰ Richard Charlton, also Geneva Richardson.

⁶²¹ *Northamptonshire Healthcare NHS Foundation Trust & Anor v ML* (Rev 1) [2014] EWCOP 2.

⁶²² See Department of Health (UK), *Care Act 2014: Statutory guidance for implementation* (2014).

⁶²³ *A NHS Trust v DE* [2013] EWHC 2562 (Fam).

⁶²⁴ *Mental Health Trust & Ors v DD & Anor* [2015] EWCOP 4.

⁶²⁵ *Public Guardian v Marvin* [2014] EWCOP 47.

⁶²⁶ *London Borough of Haringey v CM* [2014] EWCOP B23.

‘These “heroic” cases can give the impression that the law is working to protect rights, when perhaps they are more like a pressure valve, letting off steam when the system is still boiling away underneath.’

– English academic/researcher Dr Lucy Series

In contrast to the other organisations I met, MDAC operates primarily in jurisdictions where the domestic protection of rights is typically sorely lacking. Accordingly, it relies heavily on international human rights law – in particular the ECHR and CRPD – in its advocacy. While MDAC is never named on the record in cases in domestic or national courts, it is predominantly active at the national rather than international levels in litigation.⁶²⁷ In one of MDAC’s most well-known and influential cases, MDAC represented Mr Stanev in both his attempts to bring domestic proceedings in Bulgaria as well as at the ECtHR (see box below).

Challenging detention in a social care institution: *Stanev v Bulgaria*⁶²⁸

‘In 2000, Mr Rusi Stanev... was placed under partial guardianship by a Bulgarian court and a municipal employee was appointed as his guardian. In 2002, without ever having met Mr Stanev, [the guardian] had him placed in a social care institution in a remote mountainous area 400km from his home. Once there, the director of the institution became his guardian and controlled all of his affairs. The conditions in the institution, as documented by the Council of Europe Committee for the Prevention of Torture (‘CPT’), were unlivable. The amount of food was inadequate, the residents had to sleep in their coats in the winter due to the lack of heat, and the sanitary facilities were nothing more than holes in the ground in wooded areas outside the buildings of the institution. Mr Stanev had no ability to challenge this situation as he could not initiate any type of legal proceedings, including a proceeding to have his guardianship lifted, without his guardian’s consent.

‘The [ECtHR] found that Mr Stanev’s placement in the social care institution, against his will and for an [indeterminate] period of time, on the order of a government employee, meant that Mr Stanev had clearly experienced a deprivation of his liberty, a violation of Article 5(1) ECHR. The Court went on to state that a need for social assistance, such as was clear in Mr Stanev’s case, should not automatically lead to measures involving deprivation of liberty. It was the presence of a mental health condition which had led directly to the decision to place Mr Stanev in the home, and this was not a sufficient justification under the [ECHR].

‘The system of guardianship in Bulgaria meant that Mr Stanev had no realisable right to challenge the lawfulness of his detention in the Bulgarian courts (Article 5(4) ECHR). His legal standing to do so had been removed at the time he had been placed under guardianship, which the Court found to be a breach of his rights under this article. Given that Mr Stanev’s right to liberty had unlawfully been restricted, the Court went on to assess whether he would be able to have this situation recognised and compensated under Bulgarian law. The Court found that this was not the case, due to Mr Stanev’s status as a person under guardianship, and the Bulgarian government had breached his right to compensation (Article 5(5) ECHR).

‘The Court found that the living conditions Mr Stanev had to endure for seven years amounted to degrading treatment, relying on the report of the CPT. There was no suggestion of intent on behalf of the authorities to inflict degrading treatment, but nevertheless, the material conditions of the institution had resulted in this damage to Mr Stanev. Thus the Court found his right to freedom from degrading treatment (Article 3 ECHR) had been violated.

⁶²⁷
Steven Allen.

⁶²⁸
Stanev v Bulgaria (2012) Eur Court HR 46.

'The Court held that Mr Stanev's inability to access a court to review the restrictions on his legal capacity, which restricted many other rights, violated the right to a fair trial under Article 6(1) ECHR. The Court found that, in addition to the breach of Mr Stanev's substantive rights under the [ECHR], Bulgaria also did not provide a remedy for the degrading treatment he had suffered, or for the unlawful denial of his right to a fair trial. This lack of remedy constituted a breach of Article 13 ECHR.

'The Court ordered that Mr Stanev should be asked whether he wished to remain in the home and if not a re-examination of his situation should be carried out. The Bulgarian government should also ensure that Mr Stanev would be provided with the opportunity to apply directly to Bulgarian courts for a review of the restriction of his legal capacity, following its judgment on the point made on right to fair hearing, Article 6(1) ECHR. This statement was supported by Article 46 ECHR, asserting the binding force of the judgment on Bulgaria.

'The court ordered Bulgaria to pay Mr Stanev EUR 15,000 for the human rights violations he suffered'.⁶²⁹

This case was a landmark victory because it was the first time that the ECtHR had made a finding that a person in Mr Stanev's situation was being 'detained' in a social care institution. It was also the first case in which the ECtHR found a violation of the right to be free from degrading treatment in a social care setting.⁶³⁰

The value and limitations of strategic litigation

Strategic litigation can have an enormous impact. As described above, strategic litigation was important for the advancement of disability rights in England. Similarly, Bazelon's Ira Burnim said that, while there had already been some major statutory advances by the early 1970s,⁶³¹ litigation helped launch the disability rights movement in the US and has been critical to its success. Michael Perlin shared this view. Lisa Volpe also agreed that litigation has been essential to the progress of disability rights in New York, but said it was not the full story:

I think that's very much the case that litigation has a great deal to do with it, but I think to be fair to the psychiatric community and to the judicial system, I think they have recognised at various times... Certainly the huge reforms to the mental health system [that] occurred in the 1980s were very, very significant in protecting the rights of individuals who are confined and that was very much a part of the legislature doing research and listening to the mental health community [as well as] the judiciary recognising that people have civil rights that need to be protected.

Academic Dr Lucy Series was more circumspect about the role of litigation in realising human rights:

I think the law has certainly transformed the way that care is provided and the way care service users are treated, but in complex ways that can't be reduced to 'better' or 'worse'. Litigation has probably raised awareness of key rights around self-determination, but human rights litigation like the *Rabone* case⁶³² will also make providers more risk averse.

I think that lawyers can over-estimate the value of litigation. It's true that there are some absolutely fantastic human rights cases out there, but they are few and far between in contrast with the number of people whose rights may be interfered with in services. These 'heroic' cases can give the impression that the law is working to protect rights, when perhaps they are more like a pressure valve, letting off steam when the system is still boiling away underneath.

Notwithstanding the potential value and impact, there are a great many challenges to litigating on behalf of people with disabilities in closed environments. Depending on the nature of the case, strategic litigation can be incredibly expensive and resource intensive. It can also be incredibly slow. Just as it took a decade to achieve the settlement in *O'Toole* (see box 'Challenging placements in adult homes: *O'Toole v Cuomo*' above), it took almost six and a half years after filing for the ECtHR to deliver judgment in *Stanev*, and some cases which MDAC filed in 2007 are still waiting to be heard.⁶³³

Even for experienced strategic litigators, it is extremely difficult to predict which cases will be successful and deliver a practical return for the effort invested.

⁶²⁹

This case note is taken directly from MDAC's website: 'Stanev v Bulgaria' <<http://mdac.org/en/content/stanev-v-bulgaria-gc>>.

⁶³⁰

MDAC, 'Europe's highest human rights court issues landmark disability rights ruling' (17 January 2012) <http://www.mdac.org/en/17/01/2012/Europe_s_highest_human_rights_court_issues_landmark_disability_rights_ruling>.

⁶³¹

Eg *Rehabilitation Act 1973* s 504 (outlawing disability discrimination by recipients of federal funding) and the *Education for All Handicapped Children Act 1975* (now the *Individuals with Disabilities Education Act 2004*).

⁶³²

Rabone & Anor v Pennine Care NHS Foundation [2012] UKSC 2. In this case, a 24 year old woman suicided while on two days' leave from the hospital where she had been receiving treatment for depression on an informal basis (she was not detained under the MHA). She had been assessed as a high risk of suicide. Her parents maintained that the hospital should not have allowed her leave and that in doing so it had acted negligently and breached their daughter's right to life. The Supreme Court held that the hospital owed the woman a duty of care and 'could and should' have taken steps to stop her leaving, including detaining her under the MHA if necessary: [34].

⁶³³

Lycette Nelson.

Furthermore, achieving a successful judgment in court does not necessarily lead to changes in practice. MDAC, in collaboration with its local partners, has achieved some spectacular judgments at the ECtHR. However, particularly in the jurisdictions in which MDAC operates, such judgments do not simply translate into wide-scale – or even small-scale – changes in practice without significant further effort. Seeking meaningful implementation of judgments is just as important as litigation in order to have any real effect on people's lives. MDAC describes the importance of implementation activities in its strategic framework for 2014 to 2019:

A victory in a national or international court is usually only the first step to securing justice. MDAC will monitor the implementation of court judgments, publicise and circulate these judgments to ensure maximum uptake in the legal community, and advocate for law and policy reform to prevent the need for further victims to take court action. In this way, much of MDAC's advocacy will be closely aligned to its litigation. On an anniversary of a court application or a successful judgment, MDAC will issue a score-card type of report, thereby regularly and [consistently] using the same criteria... tracking governmental progress and holding States to account.⁶³⁴

One of the benefits that Lycette Nelson identified of litigating in the US compared to Europe is that the US courts have supervisory jurisdiction to oversee the implementation of their judgments and settlements they have approved (see box below, and box 'Challenging placements in adult homes: *O'Toole v Cuomo*' above). While this does not guarantee swift progress, it at least increases the level of action towards implementation.

Monitoring the settlement in *Joseph S v Hogan*: New York

'In 2011, DRNY and co-counsel settled *Joseph S v Hogan*, a lawsuit filed on behalf of New Yorkers with mental illness, but no need for nursing care, who were inappropriately discharged from New York psychiatric hospitals to nursing homes in violation of the [ADA], the Rehabilitation Act, and the Nursing Home Reform Act. The state fulfilled its obligations under the settlement agreement to identify all nursing home residents with mental illness who were discharged from psychiatric hospitals and contracted with an independent agency to assess all nursing home residents who were discharged from psychiatric hospitals. Under the settlement, the independent assessors would educate the remedy members [the people falling within the terms of the settlement agreement] about the available types of housing and services in the community, evaluate their ability and desire to live in more integrated, community settings, and make recommendations either for housing and services or for continued nursing home placement. Following community placement determinations, the State is then responsible for moving those who are qualified and want to move.

'By October 1, 2014, the contracted agency, Transitional Services Inc (TSI) completed nearly all of the assessments of 2,290 identified remedy members. Of these assessments, 31% were determined to be capable of living in the community and willing to do so. In addition, all discharges from inpatient psychiatric hospitals and units are being conducted under a revised procedure that will prevent unneeded institutionalisation of individuals with mental illness in nursing homes.

'DRNY and co-counsel have monitored the settlement through document review, quarterly meetings with defendants, as well as additional conference calls to resolve any issues as they arise. [In the 12 months to October 2014,] DRNY identified 28 remedy members who had been assessed as capable of living in the community, but were not being transitioned to community settings due to nursing home beliefs that the members could not be safely discharged. The State agreed to work more closely with the homes to ensure appropriate discharges, and to have the members reassessed by the TSI if their condition may have declined.

'DRNY and co-counsel have also worked to ensure community placement of the named plaintiff Joseph S who has been determined capable of living in the community but whose guardian, as well as the nursing home, have been opposed to community placement.'⁶³⁵

⁶³⁴ MDAC, *Strategic framework for 2014 to 2019* (2014) 18-19.

⁶³⁵ DRNY, *PAIMI Program - Annual program performance report - New York - 2014 Fiscal Year*, 22.

‘if the problem addressed is only the legal problem, you are less likely to accomplish real systemic change.’

– Mark Murphy, DRNY, New York

MDAC also faces particular challenges in gaining acceptance for ECtHR decisions at a local level. Follow-up litigation to ensure implementation is often necessary and, even then, local courts in Bulgaria, for instance, have simply said that the ECtHR ‘got it wrong’ and can therefore be ignored. MDAC’s executive director Oliver Lewis also described how civil society in Moldova (and no doubt other countries) has lost faith in litigation as a tool for achieving change. They see one person get out and getting money and media attention, but nothing changes for anyone else. Accordingly, all MDAC staff agreed that litigation alone is insufficient to achieve systemic change.

Ana Aiello is currently completing her PhD through Leeds University on the topic, *Using strategic litigation to recognise and enforce the rights of people with intellectual impairments in institutional residential settings: what is the potential and how can it be achieved in European countries?* Ana provided me with a copy of the first draft of her thesis, which comprehensively outlines the numerous challenges that organisations face in pursuing systemic change through strategic litigation for this cohort, and documents some strategies to overcome those challenges. Ana’s thesis, which she hopes to submit January or February 2016, will be an important resource for those working in this field.

Beyond litigation: other strategic advocacy tools

The need for multiple and coordinated strategies

Litigation and legislative advocacy can improve the operation of government institutions, but there must be a broader consciousness of human rights norms by the citizenry for long-term change to occur. As people are more aware of their rights, and as they are drawn into participation in the institutions of government, they will experience the empowerment that lies at the core of all human rights.⁶³⁶

Like many other people I spoke with, DRNY’s Mark Murphy noted that multiple tools and strategies beyond litigation and legal action are required to effectively address a problem: ‘if the problem addressed is only the legal problem, you are less likely to accomplish real systemic change’. Aside from litigation, DRNY uses a wide range of strategic work types, including:

- Reactive and proactive law and policy reform submissions;
- Investigations, monitoring of facilities, research and data-gathering;
- Educating and influencing policy makers;
- Outreach and community-awareness-raising education campaigns; and
- Use of media and case studies/storytelling.⁶³⁷

Jennifer Monthie also stressed the importance of using multiple strategies rather than relying on a single approach to obtain strategic outcomes:

It is important to have all of these available to be effective. For example, if you only rely on outreach and education to promote the rights of individuals with disabilities and you do not have the ability to defend those rights through court intervention then you are less effective. It is also important to understand the resources that each of these methods require. Litigation can be important but it is also time consuming and costly. That is why there is no one way that is more effective – all must be used to defend the rights of individuals with disabilities.

For Jennifer Monthie, litigation is a last resort that comes from not being able to resolve the matter through educating policy makers or negotiating with entities.

⁶³⁶ Wilson and Rasmussen, above n 498, 74.

⁶³⁷ Jennifer Monthie.

MDAC staff also agreed that having a multipronged strategy – rather than relying on litigation alone – is essential. As set out in its strategic plan, MDAC engages in a broad range of advocacy strategies to pursue its chosen goals (including monitoring human rights, holding States to account through litigation and advocacy, developing and advocating policy options, putting a face to a case and shaping public opinion) and employs a campaigns director as well as a litigation director to coordinate this.

Many of the big strategic litigators, such as Bazelon, the ACLU and Liberty, also have a lobbying arm and engage in both litigation and policy activities to achieve their mission. For instance, at Bazelon:

Policy staff promote [Bazelon's] goals in federal legislation and regulation, policy analysis and research, and technical assistance to state and local advocates [while lawyers] work on issues and cases that push the envelope to guarantee rights, consumer choice, access to services, and autonomy to people with mental disabilities.⁶³⁸

Although Bazelon's legal (litigation) and policy teams are separate, their work is becoming more integrated than it used to be.⁶³⁹ Ira Burnim was clear that, without both arms, Bazelon would not have the same status and credibility.

Similarly, Emma Norton at Liberty felt that both litigation and lobbying activities are necessary, but she said that sometimes litigation is the only way to make the government take notice.

Lobbying, campaigning and conversations with government

As most laws and practices as well as the allocation of funding are within the control of the government, one obvious way to seek systemic change is to approach the government directly to ask for it. Many strategic advocacy organisations engage in dialogue with governments to influence policy and legislative reform and some, such as the ACLU, are extremely experienced and well-oiled lobbying machines.

The receptiveness of a government to being lobbied in relation to disability rights issues varies significantly between jurisdictions and over time. Reflecting from outside, Ira Burnim sensed that political conversations in the UK were more meaningful and were able to achieve more than impact litigation compared to the US. However, Lycette Nelson felt there has been a significant attitudinal shift in the US at the federal level regarding disability issues in recent years which has created a real momentum for change. She said the current federal Department of Justice is very supportive of disability rights and community integration, for instance intervening in both litigation and policy matters against the states.

While ACLU's disability rights litigation program is still relatively small compared to that of its other program areas, its lobbying activities are significant. The ACLU is very well respected and has very good standing to approach people and make them listen. By knowing the system, Jennifer Bellamy described how the ACLU can 'change the political climate by pushing in the right places at the right time'. She said they are also aware of when it is better to get a third party to agitate or lead a campaign if they cannot put their name to it or if another agency such as the police would be more effective at selling the message.

English NGO Liberty has a lobbying team, who act as 'critical friends' of government by actively seeking to engage with and persuade them.

The NJOPD MHA has, when appropriate, engaged in both formal and informal policy and legislative activities. The agency administration identifies legislators who have a history of being sympathetic to their clients and works with agencies like the Mental Health Association to try to expand protections or rights for their clients.

MDAC does not engage in lobbying. However, it regularly engages in campaigning by providing information to policy-makers. For instance, MDAC is currently taking on the European Commission, the executive arm of the EU, to ensure that any funding it provides to European member states is directed towards community-based, human rights-compliant practices and infrastructure rather than propping up or expanding institutions (see box below).

⁶³⁸ Bazelon, 'Who we are' <<http://www.bazelon.org/Who-We-Are.aspx>>.

⁶³⁹ Ira Burnim.

MDAC's campaign about the expenditure of EU structural funds⁶⁴⁰

The EU ratified the CRPD in 2010 and is therefore bound by it. Article 4(1)(d) of the CRPD imposes a general obligation on signatories to refrain from doing anything that is inconsistent with the CRPD or that is lower than existing standards. The EU is therefore under this obligation when determining how to allocate the €325 billion in European Structural and Investment Funds ('ESIF') – intended to support development – to its 28 member states. However, when Hungary received €20 million in ESIF, it used at least part of the money to build and/or maintain long-term institutions. Similarly, Romania used €24 million in ESIF to segregate 18,000 people in institutions known to be abusive.

MDAC is seeking to establish that the EU's obligations under art 4(1)(d) of the CRPD require it to monitor how its funds are being spent by the member states, to step in where they become aware that funds are being used for activities that are not CRPD compliant and – most significantly – to provide restitution, recognition, reparations and compensation for victims who should have been beneficiaries had the funds been properly spent.

Some time ago, MDAC asked the EU Ombudsman to investigate the issue but she did not accept MDAC's complaint. However, six months later in mid 2014, she started her own investigation and recently released a report concluding that the EU has not done enough in its role to compel compliance. ESIF funding for 2015-2020 now contains a 'footnote' saying that funding must be predominantly used for community-based services.

On 17 August 2015, while I was at MDAC, the CRPD Committee met to consider the EU's initial report on its implementation of the CRPD. MDAC did not have the resources to attend the CRPD Committee's review in person but sent a letter outlining its concerns about this issue.⁶⁴¹ This appears to have been very effective because the CRPD Committee was very engaged, posing numerous questions to the EU about the issue.⁶⁴² In its concluding observations, the CRPD Committee stated that EU funding mechanisms 'continue being used for maintenance of residential institutions' and demanded that the EU 'ensure [ESIF] are being used strictly for the development of support services for persons with disabilities in local communities and not the re-development or expansion of institutions' and that it 'suspend, withdraw and recover payments if the obligation to respect fundamental rights is breached'.⁶⁴³

Another area where MDAC is tackling systemic issues at their source is its focus under its strategic plan on inclusive education. While it is currently their least developed campaign, it is one that Steven Allen has high hopes for. Segregating children with disabilities from a young age has a tremendous impact on their life and life choices. By putting such children out of sight, it is easier for society and government to ignore these issues. If people with decision-making power like government ministers had instead attended an all-abilities school, their attitudes towards disability – which create barriers that perpetuate or exacerbate that disability – would likely shift. Inclusive education could really change the face of society.

Working as it does across so many jurisdictions, it is impossible for MDAC to hold personal relationships with all relevant ministers and to understand all of the dynamics at play at any given time in each country. Accordingly, its function is often to act as a catalyst and enabler for others to progress change within their own countries. As Steven Allen explained, MDAC may 'open the envelope for conversations to take place domestically' but it recognises where it can leave partially progressed work in the hands of others while it moves on to another case. For instance, following its success at the ECtHR against Bulgaria in the matter of *Stanev* (see box 'Challenging detention in a social care institution: *Stanev v Bulgaria*' above), MDAC staff did not draft the law reform proposal or get involved in the detail of the domestic legislative response but Bulgarian lawyer Aneta Genova, who had partnered with MDAC to run *Stanev*, was involved with aspects of that on behalf of MDAC.

Limitations on overt or critical lobbying

Some organisations I met, particularly those with designated public functions or a close relationship with government, are restricted in how they lobby or are even prohibited from lobbying government for change. However, they may still seek to influence government through their institutional relationships (which play out away from public view), responding to formal requests for comment or supporting others who are in a position to deliver the message which they themselves cannot be seen to say.

⁶⁴⁰ Oliver Lewis and Steven Allen.

⁶⁴¹ MDAC, 'Open letter to CRPD Chair on the EU's financing of disability segregation' (26 August 2015) <<http://www.mdac.org/en/news/open-letter-cprd-chair-eus-financing-disability-segregation>>.

⁶⁴² MDAC, '7 things we learned about the EU's disability rights record', (28 August 2015) <<http://www.mdac.org/en/news/7-things-we-learned-about-eus-disability-rights-record>>.

⁶⁴³ United Nations Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of the European Union*, adopted by the Committee at its 14th session (17 August - 4 September 2015), 7 [50]-[51].

Reframing [issues in human rights terms] can be very powerful in shaping and shifting public opinion [and...] driving action because human rights language is the language of legal entitlement.

– Oliver Lewis, MDAC, Budapest

MHA-NYC's key policy goal is to shift funding towards a range of adequate community options to reduce warehousing and make 'less restrictive' a possibility in practice.⁶⁴⁴ They maintain close ties with government, which impacts on how they conduct their advocacy and necessitates a collaborative approach with government in order to promote sound public policy and program development. This means that for issues that require 'in your face' advocacy and agitation, such as the 'disgraceful and upsetting' situation of people with mental illness in prison, they may not be the ones to lead the charge.⁶⁴⁵ However, they may discuss policy positions and communication strategies regarding those issues with other agencies.

Due to its designated status, DRNY is prohibited from using federal funds (their main source of funding) for any lobbying activity or other activities aimed at influencing legislators and government officials.⁶⁴⁶ Despite this limitation, DRNY maintains a 'business-like' relationship with government⁶⁴⁷ and has working relationships with staff in all of the governmental state systems that provide services to people with disabilities.⁶⁴⁸

Similarly, being part of the court system means that the MHLS is prohibited from lobbying, but it does provide reactive comments on proposed legislative reforms:

It is the policy in our [MHLS] department and I believe it's state-wide that we do not lobby. The legislature will ask for comment from us on legislation that concerns mental health, but we don't reach out and solicit in any way. We really just offer comment but absolutely no lobbying is allowed.⁶⁴⁹

While it is not subject to the prohibition which attaches to US federal funding, as a '501(c)(3) non-profit organisation', MFY can still only use a certain proportion of its funding for lobbying. Nevertheless, it proactively engages in agenda-setting with government, seeking positive legislative reforms.

I would say MFY is more often is doing proactive work on the legislative side, [identifying an issue and then proactively approaching the government saying, 'You've got to fix this',] though of course there is some defensive work in trying to prevent bad laws from being passed.⁶⁵⁰

Mallory Curran, the supervising attorney of MFY's mental health law project, said that MFY's efforts to engage with the government and shape policy in this way were often effective. She feels 'really fortunate' that their experience with staff at the Department of Health and Mental Hygiene 'is that they really care a lot about the work that they are doing and really care a lot about people with mental illness and are interested in thinking about ways to better serve the people of New York. So yes we do find that they are interested in what we are doing and want to talk to us'. Mallory was excited that they have been talking with the Department about initiating conversations with Department-funded supported housing providers to get 'everyone having the same core goal of wanting to preserve housing for people, talking with them about ways in which they can engage their tenants and not take their tenants to housing court'. Leveraging the Department's influence over the supported housing providers will significantly help MFY to translate its goals into practical change.

Shaping public opinion and the role of the media

In a democracy, the government is ultimately answerable to the people. Accordingly, influencing public opinion to gain broad support for a cause and a demand for action can lead governments and others with power to change laws and policies. While many strategic advocacy organisations I spoke with attempted to shape public opinion through reframing issues and actively engaging with the media, others were more constrained in their abilities to do so directly.

⁶⁴⁴ Lisa Furst and Martin Blair.

⁶⁴⁵ Lisa Furst and Martin Blair.

⁶⁴⁶ Mark Murphy.

⁶⁴⁷ Ibid.

⁶⁴⁸ Jennifer Monthie.

⁶⁴⁹ Lisa Volpe.

⁶⁵⁰ Mallory Curran.

Since its establishment in 2002, well prior to the CRPD being adopted or coming into force, MDAC has been reframing negative experiences in the lives of people with disabilities that would otherwise be considered as private, social or health issues – like isolation, pain and hunger – as human rights issues on the global stage. Reframing can be very powerful in shaping and shifting public opinion. As Oliver Lewis explained, it is also powerful in driving action because human rights language is the language of legal entitlement. For instance, the provision of highly institutional care (such as fixed meals and bedtimes) can be reframed and addressed as a breach of human rights even if the care is ‘good’. When MDAC weighs in on a case or issue, be it in Bulgaria or Uganda, their credibility and influence helps take it from being a domestic concern to the global human rights stage, which ‘changes the field of the debate’ and can ‘catalyse a domestic shift’.⁶⁵¹ Executive director Oliver Lewis identified the transformation associated with such reframing as MDAC’s most significant achievement and impact.

Like many other people I spoke with, Bazelon’s legal director Ira Burnim emphasised the significant role that public opinion can play in seeking systemic reform and noted the importance of trying to manage it to create a positive force for change. Ira advised ‘trying cases in the newspaper if you can’, as strong public support will give litigation the best chance of success. In fact, Bazelon will generally only litigate issues if there is domestic support for the cause.

MFY also actively engages with the media by sending out press releases and contacting sympathetic reporters: ‘I would say that it’s... the relationships with sympathetic reporters that end up being the most effective’.⁶⁵² Collaborating with the New York Times enabled the adult homes advocacy project to bring widespread public attention to the plight of adult home residents:

In 2002-03, MFY worked closely with a New York Times reporter to bring public attention to suspicious deaths and inhumane conditions in adult homes. The resulting series in April 2002, *Broken Homes*,⁶⁵³ earned the Pulitzer Prize for investigative journalism for author Clifford J. Levy in 2003, and fuelled an avalanche of demands for state action to end the abuses and reform practices in and oversight of the homes. In accepting the Pulitzer, Levy credited MFY: “If not for MFY’s work, I never would have learned of the adult home system and the series in The New York Times, which continues to have repercussions, would never have come about.” (citation added)⁶⁵⁴

However, Mallory Curran said that public opinion was more divided in its sympathies for work in support of people with mental illness:

I think particularly with people with mental illness, the stigma is so strong and gun violence is so prevalent and the issues facing people with mental illness often get tied up in a very strong way with the aftermath of gun violence⁶⁵⁵... even though it rarely makes any sense to do that. I think there are a lot of... politicians and general people who think that people with mental illness are violent and that we need these restrictive laws... I think this is so ineffective and the focus should be on creating more voluntary high quality services for people to choose to engage with. So in that sense it can be very frustrating, but at other times I think, particularly with our current Mayor there is a lot of interest in income inequality and poverty and the way that poverty affects health and how it affects our entire community... I guess it depends on what’s happening in the broader world about how receptive we think people are. I know generally people think it’s important that people with mental illness and who are vulnerable have lawyers to help them stay in their apartments, or that people should be getting the public benefits for which they’re eligible.

In recent years, MDAC has been deliberately putting client faces and personal stories at the forefront of its campaigns. This emphasises the human impact of the issues and increases the appeal of its work.

When using the media, timing is also important as delay may mean missed opportunities for influence, particularly when responding to an issue, as the media and public typically have a short attention span.

⁶⁵¹ Steven Allen.

⁶⁵² Mallory Curran.

⁶⁵³ Clifford Levy, ‘For Mentally Ill, Death and Misery’, *New York Times* (28 April 2002).

⁶⁵⁴ MFY, ‘Adult Home Advocacy Project’ <<http://www.mfy.org/projects/adult-home-advocacy-project/>>.

⁶⁵⁵ This was something noted by Mark Murphy as well.

As a lawyer, it is not always possible or appropriate to comment publicly on an issue. However, information can be passed on to others who can pull the trigger. For instance, English lawyer Peter Edwards said that his firm has provided information on patient abuse to the media. Due to its connection with the court, the MHLS does not engage directly with the media or attempt to influence public opinion around issues relevant to their work or clients at all.⁶⁵⁶ However, they readily acknowledge that media coverage was particularly influential in the settlement of their case against Kings County Hospital (see box below).⁶⁵⁷

Fight to improve conditions at Kings County Hospital: *Hirschfeld vs New York City Health and Hospitals Corporation*

One of the things that MHLS principal attorney Sara Rollyson is most proud of are the changes that occurred at Kings County Hospital following the 'deprivation of rights' civil action taken by the MHLS and co-counsel.

I mean the conditions there were so deplorable I couldn't believe it was Brooklyn in 2004, it was horrific... You would meet clients who not only accepted those conditions but they thought that they didn't deserve any better because they didn't even know that there was different. We would have clients who literally were in wheelchairs and would drag themselves through soiled bathrooms because no one would help them and they weren't handicapped-accessible. Things like that are awful.

The case was the culmination of a careful and extensive documentation of conditions by MHLS staff, working with the MHLS Special Litigation Unit, the New York Civil Liberties Union and a private law firm.⁶⁵⁸ Before litigating, they had tried unsuccessfully to resolve the issues by talking to the hospital:

They denied everything and thought that we were almost making it up. [In the end, the] reason the case was resolved as fast as it was, was because there was a clip on the news which was released somehow about what had happened in an emergency room where a client had passed away... Doctors walked past her and a nurse kicked her to see if she was awake. There were notes in there that she was taking a shower when she was dead on the floor. So when that was leaked suddenly the conditions were taken seriously. It's horrible but something like that had to happen in order for things to change but our [law] suit was brought a year before that.⁶⁵⁹

Following the publicity around this incident, the matter progressed apace:

Soon thereafter, the United States District Court issued a preliminary injunction requiring the hospital to monitor [Comprehensive Psychiatric Emergency Program] patients every fifteen minutes and imposing other time frames to push the hospital into compliance with state law and professional standards of care. Also, with the preliminary injunction in place, settlement talks were undertaken with a much greater urgency by defendants and personnel changes at the top administrative and clinical levels were made. Ultimately, in January, 2010, two separate but interrelated settlement documents were executed by the City, the Hirschfeld plaintiff, and [the Department of Justice], and endorsed by the Court. These remarkable documents (a combination of 59 pages) sought to assure the transformation of [Kings County Hospital] psychiatric services from "a chamber of filth, decay, indifference and danger" into a model of a safe, humane, and therapeutic environment. In order to help ensure that this transformation [was] fully achieved and maintained, a 5 year period of monitoring by both the Court and experts [was] mandated.⁶⁶⁰

The media has also been very influential in transforming the system and lifting standards in England. In a notable example mentioned by many, a televised exposé on the physical and psychological abuse perpetrated on people with intellectual disabilities and autism at Winterborne View, a private care home, in 2011 led to significant changes in the regulatory framework. It was particularly shocking since the facility had been inspected by CQC regulators not long before the exposé. Dr Lucy Series said that this scandal triggered a 'return to the law' as the necessary method for ensuring human rights protection.

⁶⁵⁶ Ibid. See also New York Civil Liberties Union, 'Mental Hygiene Legal Services v NYC HHC (Challenging squalid conditions, abuse at Brooklyn's Kings County Hospital Center)' <<http://www.nyclu.org/case/mental-hygiene-legal-services-v-nyc-hhc-challenging-squalid-conditions-abuse-brooklyns-kings-co>>.

⁶⁵⁷ Sara Rollyson.

⁶⁵⁸ Ibid. See also New York Civil Liberties Union, 'Mental Hygiene Legal Services v NYC HHC (Challenging squalid conditions, abuse at Brooklyn's Kings County Hospital Center)' <<http://www.nyclu.org/case/mental-hygiene-legal-services-v-nyc-hhc-challenging-squalid-conditions-abuse-brooklyns-kings-co>>.

⁶⁵⁹ Sara Rollyson.

⁶⁶⁰ 'History of the Mental Hygiene Legal Service', above n 23, 11.

As another example, Lucy Series noted the case of Alessandra Pacchieri, an Italian woman with bipolar disorder detained for months under the MHA in England. She was pregnant and, as the birth approached, the hospital applied for an order to sedate her and deliver her baby by caesarean. The woman was not told about the application and the court ‘rubber stamped’ the NHS’ plan with no apparent consideration of her wishes.⁶⁶¹ Lucy said that publicity around this case ‘polarised’ the community, which has put increasing pressure on courts to be transparent in their decision-making.

Rather than relying on mainstream media organisations to report on or promote their cause, some organisations actively generate their own media. The internet has obviously made the dissemination of such content to a wide audience much easier. For example, a major part of the HCLU’s activity involves film production; they have produced over 500 films across their practice areas, including a documentary, *The Invisible*, which presents a very moving case about why societies should not lock away people with disabilities.⁶⁶² Tamás Verdes also described the successful impact of a film they made about a local authority which had voted to prevent people with disabilities moving into their town following the closing of a nearby institution.

After the HCLU published a movie on the board meeting of the local government, online media and online communities put them under pressure to withdraw their statements. A day later, László Horváth [a member of the Hungarian parliament who had earlier opposed the resettlement of people with disabilities into the community] published his own movie. He strongly distanced himself from the local government and portrayed himself as one of the most important proponents of deinstitutionali[s]ation of care in Bélapátfalva. His press release stressed that deinstitutionali[s]ation would contribute to the welfare of the whole of society. Finally, he stated that Bélapátfalva and Szilvásvárad should let disabled people settle in their community.⁶⁶³

Monitoring, researching and documenting human rights violations

Many advocacy organisations, especially legal services, rely on government reports and the research of others when making a case for change. However, much relevant information about the experiences of people with disabilities detained in closed environments is not publicly documented. Furthermore, in some countries, data collection may be non-existent, unreliable or corrupt. Therefore, gathering and documenting information about closed environments and otherwise hidden practices can be useful to bring them into the public gaze, shape public opinion and create a case for legislative and policy reform.

Legal organisations which provide high volume services are uniquely positioned to gather important information:

One of the key roles that human rights lawyers can fulfil is to collect and analy[s]e information about the situations that their constituents face. While most lawyers can conduct a cursory overview of their constituents’ needs and often are more than able to identify the critical issue, a more systemic approach to case information can better inform efforts to create change and ensure that all issues are identified. By creating even a simple data collection system, lawyers can have access to unique and valuable information. More systematically gathered information can then be used to track patterns within the justice system or the community that will need to be addressed either through legislative or judicial reform. Additionally, data that is quantitative is often more effective than qualitative data at influencing legislators, government officials, the media and other actors capable of assisting change... Human rights lawyers should be familiar with quality data collection systems and their interpretive tools.⁶⁶⁴

Such activities can also be useful in supporting strategic litigation, as shown by the Kings County Hospital case, which was the culmination of a careful and extensive documentation of conditions by MHLS staff (see box ‘Fight to improve conditions at Kings County Hospital: *Hirschfeld vs New York City Health and Hospitals Corporation*’ above).

⁶⁶¹ See Sue Reid, ‘I could feel my baby kicking inside me I was crying as I begged them not to cut me open: Mother whose baby was snatched from her womb by the State talks to the Mail’, *Daily Mail* (London, 5 December 2013).

⁶⁶² Available for viewing at <<https://www.youtube.com/watch?v=Yxp-nKIG5qc>>.

⁶⁶³ HCLU, ‘HCLU film disables protest’ (8 October 2013) <<http://tasz.hu/en/patients-rights/hclu-film-disables-protest>>.

⁶⁶⁴ Wilson and Rasmussen, above n 498, 47, 77.

Some strategic advocacy organisations go beyond simply collating their incoming case data by actively researching issues and seeking out information to support their cause. For example, DRI focuses its energy primarily on researching and documenting abuses against children and adults with disabilities, to great effect:

[DRI] reports have brought world attention to human rights violations in twenty-two countries of Eastern Europe, the Middle East, and the Americas. Our video clips have been broadcast on every continent and on CNN, ABC's Nightline, NBC's Dateline, BBC World News. [DRI] has been profiled in the New York Times Magazine and our advocacy campaigns have been supported by editorials in The New York Times and The Washington Post.⁶⁶⁵

In July 2015, DRI released a report, *No Justice: Torture, Trafficking, and Segregation in Mexico*, which focuses especially on the survivors of a blacklisted facility, Casa Esperanza. DRI had reported these abuses to Mexican authorities in June 2014 but, for over a year, authorities failed to take action. Just prior to the report's release, Mexican authorities responded to pressure from DRI, the Mexico City Human Rights Commission and the UN and shut down the institution.⁶⁶⁶

At MDAC, '[c]redible research underpins [its] work, and provides [an] evidence-base for strategic litigation and advocacy'⁶⁶⁷ It has significant experience of monitoring laws, policies and practices, most notably in respect of guardianship systems and the rights of patients/residents of social care institutions and psychiatric hospitals, and it has a good track record of this work leading to law and policy changes.⁶⁶⁸ Campaigns director Steven Allen said that MDAC will normally scope a new jurisdiction for two to four years before commencing any litigation. For instance, MDAC's work in Africa started in 2009-2010 with research programs. This scoping does not necessarily involve large-scale research; it may involve activities like developing partnerships, capacity-building, providing information and advice to domestic actors and so on. However, this research is important to inform their legal strategy and give credibility to their work: 'you need to have a jump on the domestic context before going in'.⁶⁶⁹ It was early research by MDAC around the horrors of guardianship in Eastern Europe – which is the vehicle for so many other human rights violations – that led to it being addressed. Research reports can also be critical evidence in human rights cases. For instance, documentary reports by the CPT and other organisations were critical in establishing before the ECtHR that the conditions in which Mr Stanev was held amounted to degrading treatment.⁶⁷⁰

MDAC is not a research institute (although in more generous financial times it did employ someone in a research/monitor role) so it does not want to get bogged down in research methodology. As Steven Allen explained, there is a very utilitarian purpose to their research: 'identify the points where we can use our real skills to advance human rights'. He noted that many countries fail in their CRPD obligations to conduct appropriate monitoring and research on disability rights issues. Furthermore, the research that is done is not always grounded in human rights and statistical information is not always useful in unpacking human rights breaches. MDAC does a lot of project work to frame the issues so that others can conduct research and report on them. It also develops monitoring toolkits to make it easier for others to engage in the work.⁶⁷¹

⁶⁶⁵ DRI, 'Our work' <<http://www.driadvocacy.org/work/>>.

⁶⁶⁶ Eric Rosenthal.

⁶⁶⁷ MDAC, 'Research and monitoring' <<http://www.mdac.org/en/what-we-do/research-and-monitoring>>.

⁶⁶⁸ Steven Allen.

⁶⁶⁹ Ibid.

⁶⁷⁰ *Stanev v Bulgaria* (2012) Eur Court HR 46, [212]. See also Oliver Lewis, 'Stanev v Bulgaria: On the pathway to freedom' (2012) 19(2) *Human Rights Brief* 1. See box 'Challenging detention in a social care institution: *Stanev v Bulgaria*' in text above.

⁶⁷¹ For example, the *ITHACA Toolkit for Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions*, above n 499.

In addition to advocacy, all P&As in the US maintain a presence in facilities that care for people with disabilities, where they monitor, investigate and attempt to remedy adverse conditions:

The PADD and PAIMI statutes provide the P&As extraordinary investigative access authority. P&As have:

- Routine access to all individuals with developmental disabilities in facilities providing services.
- Access (within 3 days of request) to all records of individuals with developmental disabilities and other records that are relevant to conducting an investigation
 - When the individual is a client of the P&A and the individual (or a guardian) authori[s]es such access
 - When the P&A receives a complaint regarding the treatment of an individual or if, as a result of its monitoring activities, there is “probable cause to believe that such individual has been subject to abuse or neglect” and the individual, because of mental or physical condition cannot authori[s]e access and there is no guardian, or the guardian is the state, or a non-state guardian does not respond to the P&A’s offer to assist.
- Immediate access (within 24 hours of request), without consent from another party, to all records in the event of a death, or if the P&A determines there is “probable cause to believe that the health or safety of an individual is in serious and immediate jeopardy.”

A number of state laws give their P&As additional authority, for example requiring facilities to report deaths and/or other types of incidents directly to the P&As. P&As often face resistance to their efforts to investigate abuse and neglect, and numerous cases have been brought by P&As to enforce their access rights. P&As can take a variety of actions in response to findings of abuse and neglect and usually try a combination of steps. They may litigate to enforce constitutional and statutory rights of facility residents individually or as a class action; they may issue public reports describing their findings and recommending corrective action; they may develop cooperative protocols with facilities for monitoring and making improvements; and they may provide technical assistance to facilities and self advocacy training for individuals with disabilities.⁶⁷²

Examples of DRNY’s investigative activities

Treatment and services for prisoners with mental illness

‘DRNY has undertaken a series of monitoring visits and record reviews as part of an investigation into how prisoners with mental illness receive treatment and services in New York State prisons. DRNY has used a variety of investigatory and advocacy tools, including monitoring visits, record requests pursuant to PAIMI statute, record requests under state Freedom of Information Law, and interviewing prisoners with mental illness and reviewing their records. In addition to looking at serious issues regarding the quality and quantity of mental health services, a major focus has been addressing compliance issues with New York State’s law prohibiting persons with mental illness from being placed in special housing units (‘SHU’) except under very limited circumstances. Placement in a SHU is solitary confinement, which can and often does cause significant harm to prisoners with mental illness.

‘As a result of DRNY’s intervention, DRNY has more information about the policies and practices being used in prisons and is better able to respond appropriately to both systemic and individual issues raised by prisoners with mental illness. In addition, DRNY activity has helped to ensure that compliance with the SHU Exclusion Law improves. Ongoing monitoring and other investigatory activity also has led to learning about other issues that DRNY has begun to address, such as the lack of appropriate trauma counselling for female inmates with mental illness as well as sufficient access to such programs that currently exist.’⁶⁷³

⁶⁷²
NDRN, above n 546.

⁶⁷³
DRNY, *PAIMI Program - Annual program performance report - New York - 2014 Fiscal Year*, 4.

Use of restraint and seclusion at the Central New York Psychiatric Center

'DRNY is investigating complaints of assaults, restraints and seclusion at the Central New York Psychiatric Center ['**CNYPC**']. This facility provides treatment to prisoners with serious mental illness, and has a very high level of restraint use relative to other psychiatric hospitals. A prior investigation of complaints had been conducted by the Commission on Quality Care, the former [P&A] system for New York State. After reviewing the CQC report and in light of the CNYPC's resistance to making changes to its practices, DRNY began a new investigation. DRNY obtained and completed review of clinical records of ten patients as well as records regarding several risk management interventions. DRNY will draft a findings letter commenting on the use of sideroom confinement for patient observation as an unauthori[s]ed seclusion practice; injuries from staff altercations; and lack of debriefing in restraints and individuali[s]ed planning to reduce restraints, and high level of restraint use with inmates with serious mental illness dually diagnosed with developmental disabilities. DRNY will be collaborating with [the MHLS], which represents the CNYPC patients, in calling for changes to sideroom observation practices.

'As a result of DRNY's intervention, DRNY expects to improve the internal complaint investigation process, reduce the use of restraints, and eliminate sideroom confinement that does not comply with state and federal regulations governing seclusion practices'.⁶⁷⁴

Speaking at the IALMH conference in Vienna, John Brayley, the Public Advocate for South Australia, noted that there is a history of restricting rights and intervening in the lives of people with disability without an evidence base, yet an expectation of a strong evidence base for any new ideas or approaches. This expectation poses a barrier to exploring potential improvements in practice. Notwithstanding this observation, he emphasised that highlighting empirical evidence, particularly research showing how upholding rights results in the delivery of high-quality, safe and effective practices and/or improves outcomes, will help sell the message. For instance, there is evidence that reducing the use of restraint and seclusion reduces trauma and violence, which benefits staff and patients alike.⁶⁷⁵ Similarly, economic research demonstrating the cost-effectiveness of rights-based approaches may be particularly appealing to certain audiences.

Dr Lucy Series also called for more empirical research into new ideas and practices such as supported decision-making to win people over, rather than just relying on theoretical, rights-based arguments. She is currently working on a research project at Cardiff Law School, *Welfare Cases in the Court of Protection*, which is seeking to gather robust empirical data on welfare cases.⁶⁷⁶

Collaboration in strategic advocacy

Many people I spoke with said the exchange of ideas through communication and collaboration with others was enriching and valuable for achieving better outcomes in strategic advocacy. For example, the ACLU's Jennifer Bellamy described the importance of collaboration in the sector when working towards communal goals. She said that when a new bill or issue is introduced, the ACLU will convene a meeting with other agencies and subject matter experts to educate and raise awareness about the issue but also to plan a response.

Furthermore, collaboration is often helpful or even necessary to achieve the desired reach and impact due to the resource limitations of each individual organisation:

Vital to a campaign's efficiency is the ability of human rights lawyering organi[s]ations to work with other NGOs, legal and non-legal.⁶⁷⁷

Coordination also avoids duplication of effort and therefore preserves and maximises resources in the sector.

In this section, I discuss two specific collaborative activities which are particularly relevant to strategic advocacy:

- Building strategic capacity in the sector through leadership and collaboration; and
- Partnering with others to conduct strategic litigation.

I also discuss the extent to which organisations interact, communicate and coordinate more generally with others in their sector.

⁶⁷⁴
Ibid 5.

⁶⁷⁵
John Brayley, speaking to staff at MDAC, 21 July 2015.

⁶⁷⁶
See Cardiff University, 'Health and welfare cases in the Court of Protection' <<http://sites.cardiff.ac.uk/wccop/>>.

⁶⁷⁷
Wilson and Rasmussen, above n 498, 75.

... there is a history of restricting rights and intervening in the lives of people with disability without an evidence base, yet an expectation of a strong evidence base for any new ideas or approaches.

– South Australian Public Advocate John Brayley

Building strategic capacity in the sector through leadership and collaboration

Due to their longevity, experience and reputation, some strategic advocacy organisations take on a leadership role and act to build capacity in the sector. For instance, services will approach the ACLU for guidance in raising an issue and they play both an educative and capacity-building role.⁶⁷⁸ Similarly, as well as initiating and conducting its own litigation, Bazelon plays a capacity-building role by ‘provid[ing] technical support on legal matters and serv[ing] as co-counsel on selected lawsuits with private lawyers, legal services programs, ACLU chapters, and state protection and advocacy systems’.⁶⁷⁹ Likewise, lawyers in diverse jurisdictions regularly approach MDAC for advice and assistance in their matters, and MDAC will sometimes intervene to make third-party submissions in ECtHR matters run by others, to provide information to assist the court.⁶⁸⁰

Bazelon also plays an informal oversight role by keeping an eye on litigation being done by other advocacy agencies. Legal director Ira Burnim said that they would try to intervene if it looked like the other agency was running the case incorrectly and risked setting a bad precedent. He relies on personal relationships developed with others in the field to know what they are doing, but even then he said there is not always full awareness of what is going on.

MDAC identifies ‘activating the legal community’ among its key strategic activities and it engages in a range of capacity-building activities.⁶⁸¹ As well as training, it also regularly disseminates information and toolkits to encourage and assist others to successfully engage in litigation for this cohort.⁶⁸² Another way in which MDAC has built capacity in the sector is through the mental disability law courses it has run at the Central European University in Budapest.⁶⁸³ Many of the litigators now working in this field in Europe (and further afield) are graduates of these courses, while others are working as Ombudsmen or in other related roles.⁶⁸⁴ Steven Allen said that this network of MDAC-trained graduates has become very important in progressing their cause over the years.

Partnering with others to conduct strategic litigation

A great deal of the high-impact strategic litigation I heard about was conducted by multiple organisations acting in partnership. Many organisations I spoke with described how it has become increasingly necessary to pool resources and collaborate with other agencies and private firms in order to be able to conduct more resource-intensive strategic litigation and thus expand their impact.

During the 1990s, MFY’s funding was significantly reduced and it sought increased support from pro bono law firms and New York’s private bar.⁶⁸⁵ MFY now regularly collaborates with other disability advocacy agencies as well as private firms to work on strategic litigation.⁶⁸⁶ For instance, in *O’Toole* (see box ‘Challenging placements in adult homes: *O’Toole v Cuomo*’ above), MFY partnered with Bazelon, DRNY, New York Lawyers for the Public Interest, the Urban Justice Center and Paul, Weiss, Rifkind, Wharton & Garrison, LLP.

Similarly, Ira Burnim said that, back in the 1990s, Bazelon used to conduct all of its own litigation. However, because litigation has become so slow and expensive, they now form a syndicate with a big litigation firm and one or more local public interest organisations. He has established strong relationships with the directors of public interest work at some of the big law firms to facilitate this.

⁶⁷⁸ Jennifer Bellamy.

⁶⁷⁹ Bazelon, ‘Who we are’, above n 638.

⁶⁸⁰ MDAC must request and receive individual permission from the President of the ECtHR for every third-party intervention it does, according to the ECtHR Rules of Procedure.

⁶⁸¹ See MDAC, ‘Capacity building’ <<http://www.mdac.org/en/what-we-do/capacity-building>>.

⁶⁸² For example, *Litigating the right to community living for people with mental disabilities: a handbook for lawyers*, above n 525.

⁶⁸³ These include the ‘Mental disability law in practice’ summer school which was conducted for a number of years, as well as the LLM module ‘Mental disability law and advocacy’, taught by Oliver Lewis since 2003.

⁶⁸⁴ Steven Allen.

⁶⁸⁵ MFY, *Mobilising for justice since 1963*, above n 555, 8.

⁶⁸⁶ Mallory Curran.

‘... there is no competition for clients – we all rely on each other to try to fill the gaps as much as possible.’

– Jennifer Monthie, DRNY, New York

DRNY and the MHLS also both co-counsel with other organisations, including large pro bono firms, to expand their capacity to undertake systemic impact work. As the MHLS’ Lisa Volpe explained:

On the nursing home case, we reached out to DRNY and then there was [New York Lawyers for the Public Interest, NYLPI], they were the main folks we reached out to. One reason for reaching out to NYLPI is that they have a kind of clearing house that matches up large law firms that are looking to do the pro bono work that they’re required to, so that’s a wonderful source. It hasn’t always worked in quite the way we’ve wanted but it is a way of really getting involved in the systemic litigation... I’m really the only person [at the Second Department MHLS] who does the systemic litigation, there’s one other attorney [in the Special Litigation and Appeals Unit] who does some of the work... One attorney or even two can’t do all of that work so having other organisations who can contribute an attorney or two and having a law firm that wants to put their associates into the pro bono really helps with the huge stuff.

Similarly, the case against Kings County Hospital (see box ‘Fight to improve conditions at Kings County Hospital: *Hirschfeld vs New York City Health and Hospitals Corporation*’ above) involved a collaboration between the MHLS, the New York Civil Liberties Union and a private law firm. However, Lisa Volpe said that collaborating with others still has its challenges and limits, and the MHLS remains quite limited in scale of the strategic work it can take on:

[A]s a practical matter, we can’t fund the really huge litigation and we have to partner with law firms who are willing to fund, basically to underwrite the litigation, and that’s not so easy to do and so we do it infrequently. The last one we started was in 2005, we haven’t taken on another really large case... we have so many other things that are more clearly within our mandate.⁶⁸⁷

Due to both its small size and location, MDAC is simply not in a position to conduct litigation without the involvement of others. As MDAC works across many countries and a number of continents, it relies on local lawyers, Ombudsmen, local human rights monitors and even the facilities themselves to refer cases to it for strategic litigation. MDAC also often partners with other NGOs; for instance, the case of *Stanev* was run in partnership with the Bulgarian Helsinki Committee (see box ‘Challenging detention in a social care institution: *Stanev v Bulgaria*’ above). In light of its diminishing in-house resources, executive director Oliver Lewis said that MDAC is now moving towards a model of being consultants on and coordinators of litigation – in partnership with local lawyers, large pro bono firms and English barristers – rather than conducting the litigation itself.

Accordingly, MDAC’s role is to frame and coordinate, and to support local lawyers litigating specific cases. It may not have access to complete information about a case (which may only be available in the local language), so it relies heavily on its links and personal relationships formed with local lawyers, experts and barristers. Local knowledge is essential when litigating in unfamiliar areas or jurisdictions. For instance, while I was there, MDAC was collaborating with a Ugandan organisation called Legal Action for Persons with Disabilities to bring a torture case regarding police treatment of a woman with mental illness. During a skype call to discuss the draft grounds of complaint, there was a discussion between them about the appropriate language to use, balancing what language would be most respectful with what language the judge would best understand and respond to (‘unsound mind’ vs ‘mental health issues’ vs ‘psychosocial disability’).

⁶⁸⁷
Lisa Volpe.

Operating somewhat at arm's length and being dependent on local lawyers and others to identify and pass on relevant information involves some risks (and MDAC is working to strengthen the processes regarding the provision of case-related information by partners). However, campaigns director Steven Allen was confident that a strategic angle can be found in most cases through the argumentation framed around it, and saw this as the creative part of human rights litigation.

Communication, coordination and collaboration in the sector

I was interested to learn whether and how organisations communicated with others in their sector and to what extent they coordinated their strategic activities. In particular, I was curious as to whether they were competitive or cooperative with each other in attempting to secure change.

Sector coordination in New York

Many people I spoke with in New York emphasised the importance of collaboration and cooperation with other local disability legal service organisations and disavowed any competition for clients. For instance, the director of DRNY's PADD program, Jennifer Monthie, said:

DRNY works with other disability legal service organi[s]ations and continues to foster this coalition building. These efforts help our clients to make sure we have strong voices when change is needed for our clients.

Free legal services for individuals with disabilities are very limited in New York State. Therefore, there is no competition for clients – we all rely on each other to try to fill the gaps as much as possible.

Similarly, the MHLS' Lisa Volpe felt that, 'for the most part', the New York mental health and disability rights sector is cooperative rather than competitive and that, in working collaboratively, individuals would 'set aside whatever differences they might have because it's for the good of our constituents'. She said 'if one organisation sees value in having other organisations participate, they will reach out [to others]'.⁶⁸⁸ She also said that the MHLS was not possessive of issues it identified and would 'absolutely' contact another agency and ask them to push it forward if they identified a particular systemic issue but were unable (due to resources or mandate) to take it on themselves.⁶⁸⁹

DRNY's Mark Murphy described the relationships within the New York disability legal service sector as 'generally collegial' and, while they largely work in parallel, they do collaborate on shared issues from time to time:

The groups are independent of one another, often with different specific focuses ([DRNY is] somewhat unusual in that we are cross-disability as opposed to serving people with particular disabilities). There is frequently overlap, but given the demand we don't "compete" for clients. If both working on the same issue, we generally try to collaborate if possible.

Mallory Curran from MFY reflected on the New York disability rights legal sector:

It is different [in New York] than almost all other places... the size is one thing, it's just huge, also there is a really strong culture of advocacy... [T]here's [also] more diversity of legal funding than there is in almost all other places in the country. There is some great collaboration that occurs, [but] I do think there is competition because there is competition for these different funds. Not every program is going to get all the funding, some people really have a niche that they're known for.

Natural divisions have arisen in terms of which organisation should take the lead on particular issues or with particular client populations, in part due to each organisation's key mandate, which helps avoid duplication of services and reduces competition:

You know there's a general feeling that [the] MHLS deals with the inpatient population mostly and that other organisations like DRNY or [New York Lawyers for the Public Interest] deal with people out in the community, and so if it's really a community issue, we're more likely to send it elsewhere. And that's partly because we have a particular mandate but also because they have their mandate which is governed by where their funding comes from, so that's why we sort of split it up and direct it that way.⁶⁹⁰

⁶⁸⁸
Ibid.

⁶⁸⁹
Ibid.

⁶⁹⁰
Ibid.

DRNY confirmed it focuses on settings where the MHLS may not have jurisdiction, for example, prisons and jails.⁶⁹¹

Similarly, Mallory Curran said that MFY was recognised as specialists in relation to certain types of housing, such as adult homes, and also ‘for taking on cases for people who may be quite ill or symptomatic that other programs wouldn’t work with’. She said that the Legal Aid Society is known for their ‘very vibrant homeless rights project and they’re really the experts on the shelter system’.

Mallory Curran noted that having so many different services operating in the same field is ‘mostly good, but it does have some downsides’:

I think it’s great because there’s a lot of creativity and dynamism and having different programs with different kinds of cultures is good.

It is also helpful to be able to refer cases to more specialised programs and not have to invest as much time and energy in understanding the intricacies of the issues that other agencies focus on. However, it can be confusing and inefficient for clients to try to access the most appropriate service (see ‘Service model and operational factors’ in Part 5A below).

There is no formal professional association for mental health and disability legal service organisations in New York State.⁶⁹² Accordingly, communication and collaboration between organisations seems to rely on informal networks and arises organically. However, ‘it is a very small community’⁶⁹³ and there is ‘a pretty good understanding of what everybody [in the sector] does’.⁶⁹⁴ There are also several Listserv email groups where advocates can share ideas and ask a broad group of colleagues questions, such as whether they have recommendations for an expert witness or whether they have run a particular legal issue before.

While there is no formal association in New York, there is a national professional association for the P&A system called the National Disability Rights Network (‘**NDRN**’). Being part of such a strong network is seen as a strength by DRNY staff, who feel ‘really connected’.⁶⁹⁵ It also means that DRNY is aware of what is happening in other states and can participate in a national effort towards realising the rights of people with disabilities.

Sector coordination in England

Dialogue across the sector was identified as important by many people I spoke with in England. For instance, Professor Geneva Richardson described how, when the government proposed changes to mental health law in 2000, psychiatrists, nurses, lawyers and academics all rallied against it and were united in their opposition. This opened communication and dialogue between the disciplines which she said has remained in place.

Nevertheless, veteran lawyer Richard Charlton felt that there was room for more collegiality, collaboration and communication within the legal sector. The sector and consequently the practice of mental health law is fragmented across numerous individual firms, who work in parallel rather than in a collaborative, coordinated or strategic fashion.⁶⁹⁶ The MHLA creates opportunities for discussion through meetings, conferences and other forums (see ‘Mental Health Lawyers Association’ in Part 5B below). However, Richard said that while lawyers were sometimes aware of what issues other firms are working on, more often it was only after the case had been finalised.

Similarly, Peter Edwards said that while MHLA members enjoy coming together and have done some very good work, they are ‘just a bunch of people – individuals with their own ways of doing things’. Peter said there is very little collaboration and information-sharing between lawyers and no real discussion between firms as to what cases or issues they are working on.

The lack of coordination and central planning within the sector has other risks, as individual lawyers are free to pursue their own ideas. Peter Edwards noted some examples of generalist firms pursuing higher level mental health and disability law cases without a nuanced or strategic understanding of the law and practice area, and as a result setting bad precedents which have a negative impact on others.

⁶⁹¹ Jennifer Monthie.

⁶⁹² Ibid.

⁶⁹³ Ibid.

⁶⁹⁴ Mallory Curran.

⁶⁹⁵ Alison Lynch.

⁶⁹⁶ Richard Charlton.

... it is important to avoid operating in silos: you have to get the expertise, funding and drive in the same room.

– English barrister and academic Alex Ruck Keene

Barrister and academic Alex Ruck Keene said that it is important to avoid operating in silos: you have to get the expertise, funding and drive in the same room. Similarly, Emma Norton from Liberty said it is very important not to get hung up on reputation and profile issues, such as hanging on to an idea in order to be the first one to run it rather than discussing it with the sector or tussling over which organisation should take the lead. She said such competition was very unhelpful.

John O'Donnell, who has been practising in this area since the 1970s, has a vision to expand the MHLA into a 'Royal College of Mental Health Lawyers', bringing together barristers, academics and others working in the field. It would have a research arm, a lobbying arm and a focus on substantive law rather than just representing the interests of the lawyers. He said there is strong resistance to expanding the MHLA in this way (although some barristers and academics are currently honorary members) and he did not think his vision will come to fruition.

The Law Society's Mental Health and Disability committee has a broad, multidisciplinary membership, bringing together lawyers, consultant psychiatrists, academics and a range of others. It 'has developed into being a very good academic body',⁶⁹⁷ regularly responding to proposed legislation and policies and even being paid by government to review case law on deprivations of liberty cases under the MCA. It has become very influential and has the ear of government.⁶⁹⁸ Barrister Sophy Miles, who is chair of this committee, strongly encouraged such multidisciplinary collaboration.

Sector coordination in Hungary

The disability advocacy sector in Budapest is far smaller than New York's or England's and is under much greater strain. Tamás Verdes from the HCLU felt it was a problem that the sector did not cooperate more. He said that Hungarian organisations were more cooperative in the past but this fell apart in 2010, as the incoming government was very aggressive in shutting down and limiting civil society. However, he was optimistic that there were renewed efforts to cooperate in 2015.

As change is typically driven by a number of different actors, it is helpful if those sharing the same goals work together. For instance, Tamás Verdes believes the biggest success of the HCLU's disability rights program is contributing to deinstitutionalisation in Hungary. After Hungary decided to build more institutions, the HCLU took action in collaboration with other organisations like MDAC to stop this. As a result, six big institutions are now being closed down, with most people moving into small group homes, although some are simply smaller institutions. Tamás noted this success was the product of both deliberate collaboration and independent parallel activity – 'lots of organisations working in the same direction in different ways' – such that no one person or organisation can claim responsibility but all share in knowing that they have had a contributory influence.

Conclusion

Throughout my research, it was regularly reinforced to me that strategic litigation is an important but insufficient mechanism to protect the rights of people with disabilities detained in closed environments; a variety of coordinated strategic activities are necessary. Which strategies will be most appropriate must be considered in relation to the particular issue and context, including who holds the power that is sought to be influenced.

⁶⁹⁷ Ibid, also Peter Edwards.

⁶⁹⁸ Sophy Miles, Peter Edwards.

While they varied in their approaches, the organisations I met were ambitious and creative in how they approached strategic advocacy, particularly in seeking to tackle root causes and big solutions:

By adopting strategic approaches to recurrent problems and attacking problems at their root, human rights lawyers are more likely to achieve a long-term improvement in the human rights situation of society.⁶⁹⁹

Inadequate funding and funding misdirected towards the ‘wrong’ end of the system (ie expensive, crisis-driven services and detention facilities rather than preventative, early intervention and community-based supports) were noted by many as critical problems which need to be addressed (Australia’s National Mental Health Commission has also recently called for a significant shifting of funding within the system to address this⁷⁰⁰). Ensuring that what funding there is is directed towards human rights-compliant practices and infrastructure is also important.

Strategic advocacy is resource-intensive and complex. Modern human rights lawyers need ‘to possess non-legal skills to meet the requirements of a more holistic advocacy strategy including negotiation skills, communication skills, and education methodology and advocacy skills’.⁷⁰¹ To be done well, sufficient time is also required for planning and reflecting. Given the limited funding available in the sector, rather than trying to ‘go it alone’, organisations with shared goals do well to collaborate and coordinate their activities to minimise duplication and maximise their collective impact. Similarly, it is unhelpful for services to be competitive or influenced by reputational considerations in trying to hold on to issues which they identify but do not have the capacity alone to address; what is important is that the work progresses for the benefit of the people they seek to assist.

Ultimately, the true realisation of human rights requires the hand-in-hand development of law and culture; focussing on the law alone will not work. Cultural change is clearly an impossible task for legal services to take on themselves. However, equipped with a focused human rights lens, lawyers who go into closed environments are uniquely placed to play an important contributory role in shaping public opinion and the development of a rights-respecting culture by sharing their insights and amplifying the voices of the people detained therein.

RECOMMENDATIONS AND IDEAS

- ▶ With consumer/service user and other stakeholder input, give further consideration to how MHDL should balance individual legal services with strategic advocacy and articulate a clear rationale for the settled position.
- ▶ Consider how strategic advocacy is best coordinated and undertaken by MHDL, including who leads and evaluates the work and whether collaborating with others would be beneficial.
- ▶ Facilitate a meeting of interested members of the legal community (including private law firms, community legal centres and other human rights legal organisations) to discuss ideas and consider establishing referral and collaboration networks for strategic advocacy.
- ▶ Facilitate meetings in respect of significant legal and policy proposals and other developments as they arise to plan coordinated sector responses.
- ▶ Consider strengthening links with key journalists and research institutions.
- ▶ Strengthen and refine MHDL’s data collection processes.

⁶⁹⁹ Wilson and Rasmussen, above n 498, 59.

⁷⁰⁰ National Mental Health Commission, above n 7, 8, 12.

⁷⁰¹ Wilson and Rasmussen, above n 498, 75.

CHAPTER 5:

CULTIVATING HIGH-QUALITY AND EFFECTIVE MENTAL HEALTH LEGAL SERVICES

The legal, political and policy contexts in which legal services operate significantly impact on the way in which those services are structured and delivered. Throughout this report, I have noted where particular laws, processes and attitudinal barriers have aided or hindered the ability of lawyers to protect the rights of people with disabilities who are detained for compulsory treatment in closed environments.

In this chapter, I look more closely at the lawyers and legal services themselves. In undertaking this part of the research, I was interested to learn what factors facilitate high-quality and effective mental health legal services. I was particularly curious to explore how a single, specialist legal service such as the MHLS compares to a system of disparate private firms.

The following factors were identified as having a significant impact on the quality and efficacy of legal services:

- The personal qualities, attitude and motivation of lawyers;
- Working arrangements and conditions;
- The service model and operational factors; and
- Funding and remuneration.

I have discussed the efforts to regulate and improve the quality of mental health lawyers and legal services in England in Part 5B below.

5A. FACTORS SUPPORTING HIGH-QUALITY AND EFFECTIVE LEGAL SERVICES

Personal qualities, attitude and motivation of lawyers

Mental health lawyering in any jurisdiction is challenging. The work is increasingly legally complex as legislation and policies continue to change and new human rights arguments gain traction. It can also be ethically challenging, frustrating, emotionally draining and exhausting. The advocacy environments can be tough or even hostile, especially where there is a clash of values frameworks (eg human rights, 'best interests' and medical models) and of ideas about what 'recovery' truly means. Clients may be distressed, frightened, angry or unwell, factors which create communication challenges. Furthermore, the stakes are high: a poor quality legal service may mean that a person is deprived of their liberty and other rights in circumstances where they should not be. However, motivation to do this work well cannot rely on achieving legal victories; if 'success' was measured by whether a compulsory treatment order is cancelled following a client's request, then 'wins' would be few and far between.

To provide quality legal services in these circumstances requires patience, empathy, resilience and a dedication to and willingness to stand up for the principles and values which underpin the importance of the work. All of the lawyers I met in New York and England demonstrated these qualities. They all clearly held an understanding of the rights-protecting purpose of the law and expressed collective outrage at the apparent injustices their clients faced. They were committed to advancing the best case for their clients and taking legal action in the face unfair or potentially unlawful decisions. They all spoke with great passion and enthusiasm about their work and clients and it was evident that they cared strongly about the immediate and longer-term outcomes for their clients.

Sara Rollyson said that the lawyers she works with at the Second Department MHLS are ‘knowledgeable, dedicated and passionate about the work we do and the impact it has on our clients’ lives’. She reported there is not much staff turnover – she has been there for 12 years – and she felt it was the personal passion of staff rather than employment conditions that kept them engaged with the work:

[I]n some ways it’s very routine as we do have the same hearings each week and go to the same places and see the same doctors. On the other hand, I love this work because I am not stuck behind a desk all day. I do get to go to the hospital and I love our clients and every client is so different. I like to think I have heard every story under the sun but then I hear a new one...

I believe that attorneys stay here because they do love the work and I think that’s first and foremost. If you are an attorney and you don’t love this job, not only should you not be here, I don’t think you would be here. It’s not like we are in these lofty offices with a great view.⁷⁰²

Nevertheless, she thought it was getting more desirable and competitive to work for the MHLS and that ‘the calibre of attorneys is getting better every year’.⁷⁰³

Despite working in private practices, none of the English lawyers I met, who were of a similarly high quality, were driven to do mental health work in order to make a profit. Rather, reflecting my recruitment strategy for research participants, they were all active members of the MHLA (see ‘Mental Health Lawyers Association’ in Part 5B below) and passionate about the inherent importance of the work.

Nevertheless, not all lawyers currently undertaking mental health legal services in England are similarly motivated. For many years, mental health legal services were provided by only a small number of private firms who were interested and engaged in the work. However, numerous people reported to me that, as legal aid funding was removed or reduced in other practice areas, firms that had no background or particular interest in mental health law or the clients started turning to mental health work as a new funding stream.⁷⁰⁴ The consequence of this was an influx of lawyers who had fallen into mental health work by chance and who did not necessarily possess the care, commitment and motivation of the lawyers I met.

Accordingly, Tam Gill said there are now two types of lawyers doing mental health work in England – those who are really committed to the work, who ‘get it’ and who do an excellent job, and those ‘who just want to make a quick buck’. Similarly, from an external perspective, Dr Lucy Series said that some lawyers are ‘absolutely fantastic, and really understand disability rights’ whereas others ‘hold very disablist and paternalistic attitudes’. The MHT members I met also described ‘a very variable quality of representation’.⁷⁰⁵ Similarly, a nurse at Burnley General Hospital said to me as we were chatting before an MHT hearing, ‘Some [of the lawyers doing this work] are right dopey’.

Reflections

Due to the challenges and demands involved, lawyers are unlikely to take on mental health work unless they have the personal qualities and attitudes described above. Very few people pay privately for mental health legal services⁷⁰⁶ and the work is typically not so well paid as to attract lawyers to the field unless they are already internally motivated to provide the services. It was accordingly intriguing to me that the English legal aid funding model had attracted a group of lawyers who did not otherwise seem to be internally motivated by the work, resulting in a much more variable quality of services. I have discussed this further under ‘Funding and remuneration’ and in Part 5B below.

⁷⁰² Sara Rollyson.

⁷⁰³ Ibid.

⁷⁰⁴ Tam Gill, John O’Donnell, Richard Charlton.

⁷⁰⁵ Aswini Weeraratne QC, also Dr Richard Noon.

⁷⁰⁶ This is the case in New York and England as well because publicly funded mental health legal services are not means-tested.

Working arrangements and conditions

Regardless of how highly skilled and committed an individual lawyer may be, strong organisational support and facilitative working conditions are necessary to support high-quality and effective legal services.

Funding and remuneration arrangements, which were noted to be particularly significant factors, are discussed under a separate heading below.

Adequate time for preparation and reflection

The value of thorough preparation for mental health hearings was discussed in Part 3B above, and preparation necessarily takes time. Many people also emphasised how important it is to have time to think, strategise and reflect on their own work practices, legal issues and systemic challenges, as this facilitates improved practices and more effective solutions.

As noted above, Ira Burnim said one of the good things about working at Bazelon is that there is time for reflection and discussion, which he sees as essential for good work. Sadly, however, many people noted how rare it was for them to have time to engage in these reflective practices.

Provision of professional support, training and development

Professional support, training and development enables a better quality of legal service to be delivered through directly increasing the substantive knowledge and skills of the lawyers providing those services:

[Human rights] organi[s]ations that allowed staff the time and resources to seek continued legal education benefited from the time spent improving their skills and expertise.⁷⁰⁷

Where such supports and training are provided to a group of people, they also lead to greater consistency in service delivery. The range of training and development needs of lawyers in this jurisdiction include: substantive, procedural and strategic aspects of the law; information about mental illness, disability, treatments and services; and interpersonal and communication skills. Additional skills are required for strategic advocacy activities.

Like in Victoria, the mental health and disability legal landscape in each jurisdiction is constantly changing. As a result, the MHLS' Lisa Volpe noted the need for mental health lawyers to be very flexible and continuously learning:

We're always addressing new issues as they come up and we have to be very flexible to do that. That means our attorneys always have to be learning and adapting in order to represent their individual clients as well as they must.

The NJOPD MHA provides regular training for staff, bringing in psychiatrists and other professionals to ensure that staff have a broad knowledge.⁷⁰⁸ At the MHLS, two days a year are set aside for continuing legal education, which involves a mix of internal and external presenters.⁷⁰⁹ However, Sara Rollyson noted that, being a state agency, the MHLS' resources for training were limited.

As well as regular planned training, reactive professional support and resources are also required. When new legislation or a new issue emerges, the MHLS will usually develop a protocol for their lawyers so they will be able to recognise the issues quickly and have a consistent way of dealing with them.⁷¹⁰ Similarly, Peter Edwards said that when there is a new law or practice change, the lawyers in his firm have internal meetings and discussions to come up with a standard approach to the issue.

Work group, peer support and mentoring

As noted above, mental health lawyering can be very challenging. Working alongside other people who understand these challenges, from whom you can seek guidance and with whom you can reflect and debrief is very important both for supporting the quality and consistency of legal work but also to help build resilience and maintain motivation among the lawyers. Accordingly, many people noted how helpful it is to be working in a group of peers.

⁷⁰⁷ Wilson and Rasmussen, above n 498, 47.

⁷⁰⁸ Patrick Reilly.

⁷⁰⁹ Sara Rollyson.

⁷¹⁰ Lisa Volpe.

‘It’s a hard life emotionally.’

– Hungarian lawyer Dr Adrienn Gazsi, on conducting a sole practice

Hungarian disability rights lawyer Dr Adrienn Gazsi, who has been working in the field for 10 years, described the challenges of working essentially in a sole practice. She currently works at KézenFogva Alapítvány (‘Hand in Hand Foundation’),⁷¹¹ a social services provider, where she is the only lawyer and has no assistance in running her practice aside from a ‘dispatcher’ who helps with triaging. She has no supervision and finds it both practically and emotionally challenging: ‘It’s a hard life emotionally’. Some years ago, the EU funded a project to bring her together in a network with three other disability rights lawyers, who each had different strengths and skills. During the project, they met monthly, shared cases, checked over each others’ legal documents and built a larger network. Adrienn said this was ‘really good for us and our clients’ as it helped build capacity and provided an opportunity for them to share their experiences and the emotional burdens under which they laboured. Sadly, this project has not continued.

MHLS lawyers benefit from working in groups. While on most days the First Department MHLS lawyers are out at various hospitals and spend little time together, on Wednesdays they converge in the BPC office because that is the day for court hearings at the hospital. On the day I spent with them, the staff spent the morning discussing their cases, seeking advice from each other and developing case theories. Strong mentorship and peer support within the office was evident. However, despite the MHLS notionally being a single agency operating within a single state, Sara Rollyson said there was not much collaboration with or interaction between lawyers at the different MHLS Departments (although Lisa Volpe said that the directors of each MHLS Department do meet fairly frequently to discuss issues that arise state-wide).

The open nature of the courts in the US where mental health hearings take place was also identified as a factor that promotes quality services. Compared to MHTs in England, where lawyers very rarely get the opportunity to observe each other in action, Katherine McCabe noted that being able to observe and support your peers in court allows mutual learning and skill-building, and is also a motivating factor for the advocate because there is an element of pride in wanting to provide a good service in front of your colleagues. NJOPD MHA director Patrick Reilly said he randomly visits various hospital courtrooms around New Jersey about four or five times a month to observe and monitor his staff, as well as to observe the judge, as a further quality control mechanism.

Reflections

The provision of training and professional support is typically easier and more cost effective for larger organisations with specialist practices as there is an economy of scale. Such work environments, like the MHLS and the specialist law firms in England, also provide good opportunities for peer support and mentoring. In contrast, it seems that the working arrangements least conducive to high-quality and effective mental health legal services are ones where inexperienced lawyers are working in relative isolation (such as within a generalist law firm), without colleagues or supportive network of peers.

As discussed in Part 4C, communication across the sector is also helpful; lawyers benefit not only from working with their direct colleagues but from being part of a larger professional network. The NDRN organises conferences and provides collective training, which also provide an opportunity for staff from the different P&As across the US to meet each other.⁷¹² Being part of this network means that DRNY lawyers are aware of what is happening in other jurisdictions and can participate in a national effort towards realising the rights of people with disabilities. In England, the MHFA (discussed further below) provides similar support and professional development to the profession.

⁷¹¹ See KézenFogva Alapítvány, ‘About us’ <http://www.kezenfogva.hu/about_us>.

⁷¹² Alison Lynch.

Time is a valuable resource, so whether a legal service or organisation (or the model that funds them) permits adequate time for preparation, learning and reflection depends on the perceived value of these activities. While adequate case preparation time may deliver measurable and immediate benefits in the form of more successful outcomes, it is generally harder to demonstrate the value of allocating time for thinking and reflection, which is likely to deliver more indirect benefits over a longer period of time. However, there are also costs in failing to allow sufficient time for these reflective practices, which may be equally hard to measure in financial terms but are nonetheless real and need to be accounted for. Strong, future-focused leadership within a legal service will help ensure that time for planning, learning and reflection is valued and incorporated into daily practice.

Service model and operational factors

The models for the provision of mental health legal services in New York and England are very different and there are advantages and disadvantages associated with each. In this section, I evaluate some of the operational factors associated with each model in terms of how well they support effective and high-quality legal services.

Single vs disparate services

One immediate difference between the mental health legal service models I encountered was that in New York there is a single service (albeit with different offices) whereas in England there are hundreds of unconnected private firms. A number of significant factors emerged which demonstrate the comparative strengths and weaknesses of these models.

Facilitation of client access

To be effective, a legal service must be able to connect with clients. As discussed in Parts 3A and 3D above, having a single legal service, particularly one with mandated functions and responsibilities, strongly facilitates client access. For instance, Sara Rollyson described how essentially every person in a New York mental health service would recognise the name ‘MHLS’ and have at least a basic understanding of its role.

In contrast, there are hundreds of separate entry points to receive a mental health legal service in England and much lower ‘brand’ recognition for any particular firm. Many people (particularly people brought into the mental health service system for the first time) are reliant on a list of available firms being provided to them and then picking one at random.

MFY’s Mallory Curran noted that the multitude of organisations providing broader legal and advocacy services to people with disabilities in New York causes some confusion and inefficiencies of access:

[I]t can be very difficult for people trying to access the services because there isn’t a single point of entry and so it leads to inefficiencies in terms of people not knowing who they should call, and at the same time calling six different places[, resulting in] six different programs analysing their case and making a decision because we don’t know that other places are taking a look.

However, one issue with having a single legal service is that it is harder to deal with conflicts of interest arising between clients. As Sara Rollyson explained:

[B]ecause the MHLS represent[s] all the clients in hospital, if one client has a problem with another client then obviously we can get into some sticky situations because obviously we are the other client’s lawyers as well...

If there is a conflict, and we have had some conflicts before, sometimes it’s referred up... I don’t remember the specifics but the First Department ended up handling [a case where the Second Department MHLS had a conflict]... That was a Coney Island Hospital client and they actually came in [from Manhattan] to represent them, so that was a little bit of distance for them.⁷¹³

⁷¹³ Sara Rollyson.

Client choice and competition

People in England are free to engage any one of the 300-plus contracted firms for their mental health legal matter. Such client choice in a fairly open market of lawyers is a driver of quality because there is a direct financial incentive for lawyers to provide quality services. As there are other firms ready and able to step in if they are not going a good job, lawyers must work to establish rapport with their clients and serve their needs well in order to retain their instructions (and thus the fees in the matter). Additionally, ensuring that each individual client is satisfied with the service is important for the firm's ongoing reputation, which in turn affects the chances of them receiving requests for legal assistance from other people in the future: 'If I provide a good service to a client, they'll tell one person. A bad service and they'll tell ten'.⁷¹⁴

MHA administrator Sheena Ebsworth said there were about twenty law firms on the list who provide services at Broadmoor Hospital, which she felt was a 'good number'. She thought having a range of available firms is good because lawyers can get incorporated into their client's paranoia and delusions, and sometimes clients want to change their legal representative over time if they think they are not getting a good outcome. Similarly, Sue Eades, manager of IMHA services at Broadmoor Hospital, also felt that choice was a good thing: 'Patients like to see choice as proof of IMHA's independence from the Hospital'. Lawyer Katherine McCabe thought that clients should be able to change their lawyer if they are dissatisfied with the service, which can be problematic where there is a single or dominant legal service. For example, one patient at St Elizabeths Hospital in Washington DC told me that he was unhappy at not being able to change his allocated lawyer, who he did not think was doing a good job or acting on his instructions.

English service user Ian Callaghan also felt that having so many firms offering services, and a control over the choice of lawyer, was important to ensure a good fit and quality of service: '[Y]ou want to find someone who you get on with and who you think will truly act in your best interests'. He continued:

A good lawyer is someone who is reliable, listens well, understands the case well, spends enough time with you and is very assertive. Mine certainly fits that bill – she very quickly became familiar with my case and I trusted her judgement. She was very firm during Tribunals and argued my case well. A bad lawyer would be unreliable, unprepared, not taking much interest. In my experience there aren't many like that. Most people I know have been happy with their lawyer – if not they would change them as there are plenty of them to choose from.

Authority and leadership

Being the primary provider of mental health legal services in a particular location is a significant responsibility, but it does create opportunities for influence by establishing that service as an authority which is deserving of others' attention. As the key service providers in their respective jurisdictions, the MHLS, the NJOPD MHA and the DCPDS MHD have each established institutional relationships with their local mental health services and others relevant stakeholders. They will meet with them regularly and will be consulted about significant issues affecting their core client group. They also have the authority to proactively raise individual and systemic issues affecting people at the facilities. In New York, the MHLS' authority and leadership is significantly augmented by its designated statutory functions and mandate.

In contrast, no single firm in England commands such authority. As noted above, John O'Donnell described it as a 'major defect' in the English system of privatised legal representation that no-one holds an organisational or institutional relationship with the detaining facilities, which would bring with it the standing to seek audience and engage in dialogue about systemic issues. He said that he had tried to initiate forums of this nature in the past but they had come to nothing.

In addition, where a single mental health legal service provides all or the vast majority of legal services in its jurisdiction, it will necessarily have gathered a vast amount of information through the high volume of its casework and representations. Having that information consolidated in a single location will reveal patterns and trends about the practical operation of laws, mental health services and decision-makers. The service can then use that information as an evidence base to address the identified systemic issues through strategic advocacy.

⁷¹⁴
Tam Gill.

‘If I provide a good service to a client, they’ll tell one person. A bad service and they’ll tell ten.’

– English lawyer Tam Gill

Development of local knowledge and relationships with services

Where a single service is constantly in attendance at the same hospital or facility (which they will be if they are the only legal service), it will be easier for the lawyers to establish relationships with staff, gain a longitudinal perspective on how the facility functions and notice and respond to any changes in practice. As discussed in Part 3C above, this can be extremely helpful for gathering information and for influencing administrative decision-makers and the culture of the hospital more generally.

Having a strong understanding of how a particular mental health service functions also assists in evaluating their evidence and holding them to account in individual hearings.⁷¹⁵ For instance, where the hospital presents an explanation as to why psychology is not taking place or why there has been a delay in securing discharge accommodation, a lawyer with a longitudinal understanding of that service might know, for instance, that there has been a high turnover in psychologists or other operational factors which are impacting on the provision of services, and that the same explanation was presented six months ago with an assurance that it would be resolved shortly. Armed with that knowledge, the lawyer can then advocate more effectively in the case at hand by challenging the explanation provided. However, a lawyer providing only occasional services at that location may not be in a position to do so.

While the MHLS is clearly well-positioned to develop local knowledge and relationships with services, not all lawyers in England are able to do this. Firms that specialise in mental health work will often allocate work so that a particular lawyer covers particular hospitals. In this way, the lawyer will attend the hospital fairly regularly. Peter Edwards’ staff said they get to know staff at their hospitals well. My observation of the interaction between their colleague and the staff at Warrington Hospital confirmed this; the lawyer was clearly known to staff as they chatted with her and offered her lunch in the staff room. Nevertheless, Katherine McCabe, who has worked in both jurisdictions, felt that MHLS lawyers on the whole have stronger relationships with hospital staff than English lawyers do due to their institutional standing and constant presence.

Tam Gill described the importance of lawyers having good relationships with mental health services in order to get information needed to prepare cases: ‘You can’t do your role if you don’t have a good relationship with them’. The number of psychiatrists who spoke highly of her to me confirmed that she does indeed hold good relationships with them. However, firms that take on only occasional mental health matters provide services without the benefit of such relationships and essential local knowledge, which will inevitably reduce their quality and efficacy. From a mental health service perspective, Sheena Ebsworth identified regularity of attendance as a key factor contributing to a good relationship between lawyers and services, along with knowledge of and respect for each others’ roles and communication with the hospital (for instance, giving a ‘heads up’ that an application is being made).

Lawyers who do not appreciate the value of good relationships with mental health services and behave poorly put at risk the ability of other lawyers to maintain open and effective relationships with services, because it reduces the general trust and goodwill of services towards lawyers. This is far more likely to occur where there are multiple legal service providers with different approaches and motivations. I was told that some firms in England have been dreadful in their interactions with services, which makes services wary of lawyers;⁷¹⁶ one service even had to call the police to have a lawyer removed after he refused to leave (see further discussion in Part 5B below). As a result, some hospitals and trusts have published their own codes of conduct for lawyers, ‘which are circulated periodically following particularly egregious conduct by a minority of legal representatives’.⁷¹⁷

⁷¹⁵ Katherine McCabe.

⁷¹⁶ Tam Gill.

⁷¹⁷ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 122.

While strong and respectful relationships between lawyers and hospital staff facilitate good practice, it is nevertheless important that lawyers maintain, and are seen to maintain, independence from the hospital. For instance, Tam Gill stressed that, even if friendly with particular staff members outside, it is important to maintain professional independence when at the facility and in client discussions. She felt that both she and the psychiatrists she deals with take their roles very seriously in this regard. Katherine McCabe queried the impact of their familiarity on patient perceptions of the MHLS' independence when, for instance, MHLS lawyers spoke with hospital staff about their weekends. Coming from the English model of decentralised, private legal services, she said she had expected early on in her time in New York that MHLS lawyers would be seen as the hospital's lawyers by patients and would be less forceful in their advocacy as a result of their closer relationships with hospital staff. However, she said that this is not what she has observed in practice.

Reflections

Being the single or at least a very regular provider of mental health legal services at a particular hospital facilitates high-quality and effective legal services because lawyers will be able to use their longitudinal local knowledge and institutional relationships to gather information, scrutinise evidence and advocate more effectively. Having a statutory mandate further augments these advantages. However, the more that mental health legal work is spread between service providers, the more these advantages are diluted.

At MHDL, we have found that having the same lawyer in attendance at each hospital week after week is extremely important for our advocacy. There are many occasions where we have been able to advocate effectively where, had we not had an intimate, longitudinal knowledge of the practices of each facility, we would otherwise have been blind to the issues at play. However, where change is not forthcoming, it can be very frustrating and demotivating for lawyers to confront the same issues with the same staff time after time.

Specialist vs holistic services

Another variable between service models is the range of work undertaken. Some services specialise purely in mental health and disability law matters whereas others provide a broader range of other legal services and/or non-legal services.

Breadth of legal matters

It would be efficient and helpful for a single lawyer or legal service to be able to address the range of legal needs an individual client might have. However, everyone I spoke with was clear that mental health legal work is a specialised area of practice that requires considerable expertise and experience. To advocate effectively in this field, it is necessary for lawyers to be across current and emerging practices in treatment and service system issues, as well as recent developments in the law. Unless mental health legal work is conducted regularly and at reasonable volumes, it is extremely hard to gain and maintain this knowledge. For instance, Katherine McCabe was impressed with how much MHLS lawyers knew about the medications being proposed for their clients and their ability to cross-examine in detail based on their familiarity with these during 'treatment over objection' hearings (eg whether a particular medication was contraindicated for a person with diabetes and what alternative treatment could be considered). Inevitably, while there will always be limits to lawyers' clinical knowledge, such knowledge will be far less developed in lawyers who practice in the area only occasionally, which will limit the efficacy of their advocacy.

Furthermore, maintaining a limited focus may improve strategic impact:

[Human rights lawyering] groups that strategically limit their legal work to specific rights or issues are typically more effective at achieving a greater impact on society.⁷¹⁸

⁷¹⁸ Wilson and Rasmussen, above n 498, 103.

In England, many of the firms I met specialised in mental health work. However, the majority of firms with contracts to provide mental health legal services also undertake a wide range of legal work, depending on what other legal aid contracts they have and what clients are willing to pay for. Richard Charlton and Peter Edwards thought that increased specialisation brought about through the specific practice area contracts has improved the quality and consistency of legal work generally. John O'Donnell also felt that specialisation was a good thing until it 'comes at the exclusion of other areas of practice'. John stated with some sadness that lawyers used to be able to provide more holistic legal services to mental health clients funded by legal aid, but that is no longer the case due to funding restrictions.

In contrast, the scope of the MHLS' services is set by its statutory mandate, which limits the range of work it can undertake and prevents it from providing more holistic legal services. Similarly, the MHLS is limited in the settings where individuals may be represented. While Sara Rollyson felt there are 'some benefits in having a whole holistic approach', she ultimately felt that remaining a focused, specialised service is more effective than trying to stretch yourself to meet all of your client's legal needs. They rely on referrals to other services to meet their clients' typically broad array of legal and other needs. For instance, individual complaints about care and treatment by staff are referred to other services such as DRNY.

Sara Rollyson said that the MHLS responds only to issues that the client brings to them and does not actively seek out information about other legal issues they may have, both out of respect to the client and because it may have an adverse impact on their mental health legal case:

[I]f you want to make a certain argument sometimes it's better not to know. I mean our clients do have this breadth of issues sometimes. If it's something that is very obvious usually they will bring it up or they will ask us to call their other attorney. But usually it's very narrowly focused on them wanting to get out of the hospital or their immediate issues.

... [A]ll of that information can also hinder their discharge from the hospital. So if they need social security for any reason or if they need housing, they might not want it or not want it immediately as it means delaying their discharge.⁷¹⁹

In contrast to the MHLS, MFY deliberately takes a more holistic approach to legal service delivery and actively seeks information on legal issues which their client may not otherwise volunteer:

They may come in with a housing case and we find out that they can't pay their rent because they got cut off from social security and so we're trying to screen for other issues because we're always trying to have longer term stability for people.⁷²⁰

Engagement with non-legal issues and use of in-house social workers

Another service model variable is the extent to which non-legal issues are addressed and, if so, whether specialist staff such as social workers are employed to assist.

Michael Perlin felt it was very important for legal services to employ non-legal staff such as psychiatric nurses. In 1978, the Task Panel on Legal and Ethical Issues of the US President's Commission on Mental Health also recommended the employment of non-legal professionals in its proposed best practice service model:

In addition to attorneys (an "indispensable element in seeking and securing many types of remedies"), the advocacy system should be staffed by persons trained as "mental health professionals" (e.g., social workers and psychiatrists who provide advocacy services), lay advocates, and present and former recipients of mental health services, so as to provide a full-time staff with the necessary academic training and practical experience to provide full advocacy services for its clientele.⁷²¹

Quite a few legal services I met in the US employed social workers to provide non-legal services to clients. For instance, MFY employs a masters level social worker, has four masters level students on placements at any given time during the academic year and employs two students full-time over summer.⁷²² Mallory Curran reported that much of their work is with the mental health law project, where they provide a wide range of supports. For instance, they may be involved in helping to secure accommodation to facilitate a person's release from hospital, figuring out what is going on with their social security benefits, 'following up with case workers or figuring out what's needed (who wants what paperwork, finding paperwork, faxing the paperwork, figuring out what resources the patient would have available to them, things like that)'.⁷²³

⁷¹⁹ Sara Rollyson.

⁷²⁰ Mallory Curran.

⁷²¹ US President's Commission on Mental Health Task Panel on Legal and Ethical Issues, 'Mental Health and Human Rights: Report of the Task Panel on Legal and Ethical Issues' (1978) 20 *Arizona Law Review* 49, 56.

⁷²² Mallory Curran.

⁷²³ Ibid.

‘We don’t do what’s in our clients’ best interests, we do what they want within reason... I think just having that voice on their side is very important.’

– Sara Rollyson, MHLS, New York, on the scope of a lawyer’s role

Similarly:

- The DCPDS MHD has a social worker on staff who assists with discharge planning;
- The NJOPD MHA in New Jersey (which Michael Perlin used to run) employs ‘investigators’, who are usually social workers with either 30 psychology credits or experience in working with people with special needs;⁷²⁴
- The New Jersey P&A employs ‘advocates’ (often social workers) as well as attorneys because many of their client contacts relate to non-legal issues which the advocates are better placed to deal with;⁷²⁵ and
- While DRNY (the New York P&A) describes all of its work as being legal work,⁷²⁶ its PAIMI program does employ three staff members who are ‘non-attorney case workers/mental health advocates’.⁷²⁷

However, not everyone thinks that mental health legal services should deal with non-legal issues, particularly best interests-based social work. The Second Department MHLS does not employ any social workers or non-legal advocates. Sara Rollyson saw the scope of a lawyer’s role very clearly:

We don’t do what’s in our clients’ best interests, we do what they want within reason... I think just having that voice on their side is very important. To let them know that we are there for them and I’m not going to tell them what to do or tell them what I think.

This understanding of a lawyer’s role also led Sara Rollyson to query the appropriateness of legal services getting too far into the provision of social work.

Similarly, private law firms in England are squarely in the business of legal work. Tam Gill described doing a bit of social work ‘because we care’ but said that she tries to stay out of it because ‘others can do it’. The purist legal service model is complemented in England by the statutory non-legal, instructions-based advocacy services provided by IMHAs and IMCAs.

Regardless, even if they are not engaging in non-legal services themselves, lawyers do need to have an understanding of the non-legal issues which interrelate with the legal matters. Staff at Broadmoor were keen for lawyers to be more involved in matters that are not purely legal, such as patients’ CPA meetings, to get a better understanding of the context of their work and Sheena Ebsworth was pleased that some lawyers are doing this regularly now.

Having a social worker or other non-legal professional on staff can assist lawyers in developing their understanding of social and treatment issues, as well as to build their interpersonal and communication skills, all of which can lead to better quality and more effective legal services. For example, NJOPD MHA director Patrick Reilly said the supporting role of the investigators allows the lawyers to argue ‘not just on the law but on clinical issues’, and that knowing what treatments and services are available makes them more effective in their advocacy.

At MFY, the social workers also provide advice and tips to the lawyers to assist them to work more effectively with their clients, and provide non-legal support to the clients so that the lawyers can focus on their legal role:

They’d also give us tips. Lawyers can tell the social worker... this patient or this client is having problems and I’m really having problems communicating with this person, then they can think about strategies to use and think about does it make sense to have a social worker talk with them too, or are they so anxious that we should send a social worker to court. Then the lawyer can do the legal part and that client feels safe because they have an advocate who is with them, but that doesn’t have to be the lawyer.⁷²⁸

⁷²⁴
Patrick Reilly.

⁷²⁵
Alison Lynch.

⁷²⁶
Jennifer Monthie.

⁷²⁷
DRNY, PAIMI Program - Annual program performance report - New York - 2014 Fiscal Year, 3.

⁷²⁸
Mallory Curran.

Mallory Curran felt ‘there is a real need especially among the legal staff to get more familiarity with some of those tools and skills’ to work more effectively and efficiently with their clients, including learning how to set boundaries around the help they can provide.

Reflections

It would be ideal if a single lawyer could provide all of the legal services a particular client might ever need because the continuity of the relationship would avoid the need for the client to repeat their story over again. However, it is impossible for a single lawyer to provide quality services across every practice area. The more practice areas they cover, the less likely it is they will have the in-depth knowledge, skills and experience necessary to provide high-quality and effective mental health legal services.

In all likelihood, clients with multiple legal issues will need separate lawyers to address each issue (depending on their complexity). Arguably, whether or not these lawyers work in the same service as the mental health lawyer matters less than how smooth and efficient the referral and transfer of relevant information between them is.

Even if they do not provide legal services in other areas, mental health and disability lawyers should have at least a sufficient familiarity with other legal issues that commonly co-occur (such as discrimination, social security and housing issues) to be able provide initial advice and understand how those legal matters may affect the specific legal matter with which they are dealing.

In Victoria, MHDL essentially just provides legal services in relation to disability-specific laws for compulsory treatment, preventative detention and substituted decision-making. This focus allows us to develop specialist expertise. However, MHDL (both organisationally and physically) sits within VLA’s Civil Justice program, which provides legal assistance in relation to a wide range of matters including discrimination, social security benefits, migration, housing and infringements. Other directorates within VLA provide criminal law and family law services and there are clear internal referral protocols and communication pathways between all sections of VLA to facilitate holistic legal assistance. In addition, many of the lawyers currently employed in MHDL came through a one or two year graduate or ‘new lawyers’ training program at VLA, during which they spent time working in a range of other practice areas. Accordingly, many MHDL lawyers have the knowledge and skills to provide preliminary advice to their clients about a broad range of legal matters and will sometimes provide direct representation in those matters as well as the mental health or disability matter.

As well as understanding a range of legal matters, in order to provide the most effective legal advice, it is important for mental health lawyers to understand their clients’ interconnected non-legal issues and context. They need both the skills to notice these issues and the knowledge and connections to make appropriate referrals. There are some benefits to having non-legal and social work services available in-house, including the support they can provide to the lawyers to facilitate better quality legal services. However, it is important to remain focused on their client’s wishes and not slip into paternalistic, best interests advocacy. It is also worth noting that it may be off-putting to some people to have a legal service attempting to assist them with matters beyond the specific legal issue with which they want assistance.

In any event, it is not appropriate for lawyers to (attempt to) fill the role of social worker. Aside from lacking the specialised training to do this, it is time-consuming and detracts from the lawyer’s ability to provide high-quality legal work.

In Victoria, MHDL lawyers have customarily provided varying degrees of non-legal support to their clients, but this became increasingly unsustainable as greater demands for legal services arose. It struck me that the purer legal focus which English mental health lawyers have has perhaps resulted in them being able to do more sophisticated legal work and follow legal cases through to their conclusion in higher courts where appropriate. The recent commencement of VLA’s IMHA services should assist MHDL lawyers to retain a clear legal focus because IMHAs will have the skills and resources to advocate in relation to broader, non-legal issues on behalf of compulsory patients who want that assistance.

Funding and remuneration

As already discussed in this report, the amount of funding which a legal service or other organisation receives will impact on the scope of activities it undertakes and the extent to which it can meet demand for services and fulfil its mandate (if it has one) (see Part 3A above in relation to individual mental health legal services and Part 4C above in relation to the ability to undertake strategic advocacy). However, the sufficiency of funding, along with the particular model of funding or remuneration, may also have a significant impact on the way in which lawyers undertake mental health and disability legal services and therefore on the quality of those services.

Of all the factors influencing the evolution and quality of mental health and disability legal services being delivered in England, changes in funding (and the funding model) was the most commonly mentioned. For instance, Richard Charlton, who has been practising in this area for over 30 years, described funding as 'key' to the stability and success of a legal service, and said that legal aid is the biggest problem facing mental health lawyers currently.

Legal aid funding cuts were mentioned by almost everyone I spoke with in England as a threat to protection of rights and was the subject of much discussion at a seminar I attended in London, *Public law in an age of austerity*.⁷²⁹ Beyond the mental health context, the issue of legal aid funding was also commonly mentioned in the mainstream media and, while I was there, lawyers arranged strikes in protest at the latest round of funding cuts/changes.⁷³⁰ Aswini Weeraratne QC said it looks as though England is heading down a path where legal aid will be reduced to a limited service only for matters where legal representation is considered necessary to enable a fair hearing (such as mental health hearings). Richard Charlton said that mental health law has only hung onto its funding because of these human rights requirements.

I was interested to learn just how this situation has impacted on mental health legal service provision in England. Accordingly, after looking at the impact of sufficiency of funding and remuneration models on legal services in general, I explore in more detail below the impact of the specific Legal Aid Agency funding and remuneration model on the quality of mental health legal services in England.

Sufficiency of funding

Particularly where a legal service's funding is fixed for a period of time and does not fluctuate in accordance with the number and type of services actually provided, the number of lawyers employed and legal hours available within that service will be fixed. Where demand exceeds the available hours, one or more of the following will happen:

- Potential clients will be turned away;
- The scope and depth of services will be reduced (for instance, only advice rather than representation will be provided); and/or
- The quality of services will drop (for instance, cases will not be properly prepared – the importance of preparation was discussed in Part 3B above – and important auxiliary activities such as planning and reflection will be cut).

If the lawyers have the personal qualities and attitudes described above, they are likely to stretch themselves in the face of insufficient funding to (try to) meet demand by working additional, unpaid hours. This practice – familiar to MHDL – was noted by many of the lawyers I met in each country and is typically self-imposed or part of a shared workplace culture rather than a unilateral expectation demanded by a manager.⁷³¹ This is not a sustainable practice and comes at a significant personal cost to the lawyers involved. However, the alternative involves turning away or failing to adequately help people whose human rights are at risk, which is difficult to do because it offends the very values that led the lawyer to work in this field in the first place.

Remuneration model

Aside from the raw quantum or sufficiency of funding for legal services, whether lawyers work on a guaranteed, fixed salary or have a personal financial incentive attached to the work (in the form of a commission, bonus or staying in business) can also affect quality, either positively or negatively.

⁷²⁹ For details, see <<http://www.1cor.com/1140/records/598/Public%20Law%20in%20an%20Age%20of%20Austerity%20Flyer.pdf>>.

⁷³⁰ Eg 'Legal aid cuts: lawyers to begin boycott that could see courts grind to a halt', *The Guardian* (30 June 2015).

⁷³¹ Eg Alison Lynch.

... while there are still ‘many excellent and dedicated legal aid lawyers out there... many firms are struggling to do this work as it is financially unsustainable’.

– *English academic/researcher Dr Lucy Series*

A fixed salary may mean lack of competition and drive, with no imperative to build rapport with the client. Some English lawyers were wary of the quality and cost-effectiveness of salaried lawyers, particularly public servant-style lawyers, as they told me that a recent trial of in-house, salaried criminal defence lawyers had performed poorly compared to private lawyers. Alternatively, having a guaranteed, fixed salary rather than receiving a fee per case, especially a fixed fee per case, may free the lawyer from the pressure to cut corners to increase the profit margin in the work, and allow them to focus more fully on their client’s best legal interests.

Similarly, having a financial incentive to obtain and retain client instructions can drive both quality services (where there is a competitive market) as well as underhanded practices which are not focused on obtaining the best outcome for the client (see examples in Part 5B below).

The impact of the remuneration model in practice will ultimately depend on the personal qualities of the lawyers undertaking the work, the context in which they practice and the existence and efficacy of any external regulation.

Impact of the Legal Aid Agency funding and remuneration model in England

The Legal Aid Agency introduced contracting for mental health law work in 2000, which included a fixed fee model of legal aid in MHT matters.⁷³² Prior to that time, lawyers were paid at an hourly rate for the work they did. Since the introduction of the contracts, the funding has ‘gone consistently downhill’; Richard Charlton estimated that there has been a 50% reduction in funding in real terms for this work, which has had a ‘real impact on the quality of work’.⁷³³ Dr Richard Noon also felt that the cuts to legal aid had really affected the quality of legal services and that it came through in the advocacy he sees when sitting on the MHT.

The change from an hourly rate to a fixed fee model has removed the profit margin from the work (assuming the case is properly prepared). Lawyers respond in one of two ways: either by cutting corners and providing a poor quality service (see Part 5B below) or, as many of the lawyers I met said they did, operating without any profit or even at a loss to themselves because they feel the nature of the work is so important they have no other option. The MHT Advisory Group examined the impact of the contracting arrangements and introduction of a system of fixed fees for legal representation and was ‘concern[ed] that some solicitors are withdrawing from this specialist area of work, and that cuts in legal aid funding are leading to a deterioration in the standard of representation at tribunal hearings’.⁷³⁴ Even as a researcher/academic, Dr Lucy Series noted that while there are still ‘many excellent and dedicated legal aid lawyers out there... many firms are struggling to do this work as it is financially unsustainable’.

John O’Donnell, who has been practising in this area since the 1970s, described the ‘huge impact’ which legal aid funding cuts have had on their work. He said it is very hard running a firm where you believe in the importance of the work and the need to spend time to do the work properly but the money simply is not there. He has had to cut down on staff as a result and they now spend more time doing other areas of practice. For instance, mental capacity work in the Court of Protection is more profitable than mental health work. Regardless, if he feels it is important, he, like other lawyers I spoke with,⁷³⁵ will still run a case pro bono if legal aid will not fund it.

⁷³²

The cumulative amount payable for a typical Mental Health Tribunal matter (including the initial advice, negotiation, preparation and appearance) is £744 (around AU\$1580).

⁷³³

Richard Charlton explains the issues further in his article, ‘Impact of Legal Aid proposals on mental health representation’, *Adjust* (December 2007).

⁷³⁴

CQC and Administrative Justice and Tribunals Council, above n 159, 10.

⁷³⁵

Eg Richard Charlton.

[A lawyer] picking up only the occasional, ad hoc matter and who does not provide rights-focused representation may be worse than no lawyer at all.

– Emeritus Professor Michael Perlin, New York

⁷³⁶ The 'escape fee' clause provides that, if the case costed at the hourly rate comes to more than the total of three times the standard fees payable plus the total of any additional fees (eg adjournment fees), the lawyer is entitled to be paid the full cost of the case at the hourly rate. Any case where the escape fee clause is invoked will be individually scrutinised by the Legal Aid Agency: MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 128.

⁷³⁷ MHLA, *Response of the Mental Health Lawyers Association to consultation on proposals to reform of legal aid in England and Wales* (2010) [2.2].

⁷³⁸ Richard Charlton.

⁷³⁹ Ibid.

⁷⁴⁰ Ibid.

⁷⁴¹ Charlton, 'Impact of Legal Aid proposals on mental health representation', above n 733, [8]. The escape fee clause is explained at footnote 736 above.

⁷⁴² Richard Charlton.

⁷⁴³ Those Regulations provided that legal aid funding for DOLS proceedings would only be exempt from the means test while a DOLS authorisation was in force. However, the Court of Protection's practice is to discontinue the authorisation and instead rely on its own powers to 'hold the ring' while it is determining the application (*Re HA* [2012] EWHC 1068 per Charles J). This meant that many people coming before the Court of Protection in these matters were no longer exempt from the means test. During *Re UF*, the Ministry of Justice accepted the principle that non-means-tested legal aid needs to remain in these cases to satisfy art 5(4) of the ECHR (following European caselaw on this issue, as per *Winterwerp v Netherlands* (1979) 2 EHRR 387 and *Megyeri v Germany* (1992) 15 EHRR 584); see also Richard Charlton, 'Non-means tested legal aid restored for patients detained under Mental Capacity Act 2005', *Family Law Week* (8 December 2013).

Richard Charlton said there has been a 'clear drift under financial pressure to do a lower quality of work within the fixed fee system'. He has seen this first hand as a peer reviewer (see 'Peer review' in Part 5B below). He said that MHT cases are not cost-effective to run any more – he may lose £700-800 on a case in order to properly prepare and conduct it. As a result, his firm deliberately does not take on many MHT cases any more and, when they do, they take the most complex cases which can be paid at an hourly rate under the 'escape fee' clause.⁷³⁶ In contrast, he feels that the approach of most firms is to try not to exceed the fixed fee, and that they do not look particularly carefully at whether they should take appeals to the Upper Tribunal. In Richard's firm, MHT work is offset by more profitable work in other areas of practice like the MCA. He said that some firms are able to make a profit from mental health work but it is very difficult to do so. Accordingly, many specialist lawyers have abandoned MHT work since the fixed fee model was introduced in 2000,⁷³⁷ and Richard said he would not advise a firm to take up MHT work. Nevertheless, he felt that there is 'still a major residue of goodwill towards the work', and the quality of legal services is kept up by the out-of-hours work of dedicated lawyers.

Aside from the quantum paid, Legal Aid Agency guidelines and conditions regarding what work will be remunerated in what circumstances also impact on the provision of legal services. For instance, as noted above, permission is required from the Upper Tribunal in order to proceed with an appeal there. However, the Legal Aid Agency funding conditions mean that the lawyer's preparation of the appeal will not be remunerated if the Upper Tribunal does not grant permission. This creates a financial disincentive for lawyers to take matters to the Upper Tribunal,⁷³⁸ which has a flow-on effect on the effective protection of patient rights.

Efforts by lawyers to influence the Legal Aid Agency

The MHLA (see 'Mental Health Lawyers Association' in Part 5B below) was founded in 2000 in response to the Legal Aid Agency introducing contracting,⁷³⁹ essentially as a union for lawyers practising in this area. It was felt that the Law Society's Mental Health and Disability Committee did not fully understand and was not able to deal with the issues that were affecting mental health lawyers on the ground, and did not appreciate the difficulties lawyers faced in dealing with the Legal Aid Agency, the MHT and the Ministry of Justice.⁷⁴⁰ The MHLA has a sub-committee to deal with legal aid issues and meets regularly with the Legal Aid Agency to discuss concerns.

English lawyers are not afraid to directly challenge decisions about legal aid funding in the courts, or raise such concerns in the course of substantive matters, in order to preserve their entitlement to adequate funding on behalf of their clients. For example:

- In 2006, the MHLA issued judicial review proceedings to challenge 'disastrous' 'escape fee' assessments on MHT casework files, 'almost all' of which were resolved in favour of the lawyers.⁷⁴¹
- In 2007, the Law Society financed a case against the latest round of funding cuts and won the case based on European competition law, which resulted in a 10% increase in funding for mental health law work.⁷⁴²
- In 2013, Richard Charlton's case of *Re UF* [2013] EWHC 4289 (COP) pressured the Ministry of Justice and Legal Aid Agency to restore non-means-tested legal aid to people deprived of their liberty under the MCA who had been caught out by the *Civil Legal Aid (Financial Resources and Payment for Services) Regulations 2013* (UK).⁷⁴³

- In March 2015, a group of lawyers were successful in their High Court challenge against legal aid regulations which had made payment for judicial review work conditional on permission being granted by the court (meaning that, even if you had legal aid approval, you may not be paid for your preparation if you are not granted permission or if the matter does not proceed for some other reason).⁷⁴⁴
- In July 2015, the Howard League for Penal Reform and Prisoners' Advice Service obtained leave from the Court of Appeal to judicially review the legality of the changes introduced by the *Criminal Legal Aid (General) (Amendment) Regulations 2013*, by arguing that the removal from the scope of criminal legal aid funding of seven types of prison law cases creates an unacceptable risk of unfair decision making.⁷⁴⁵
- Also in July 2015, in a test case originally brought on behalf of a blind man who has cognitive impairments, the High Court ruled that the Legal Aid Agency's 'exceptional case' funding scheme, which was intended to ensure that funding is available where failure to provide funding would breach the person's human rights,⁷⁴⁶ was 'wholly unsatisfactory [and] not reasonable'.⁷⁴⁷ Justice Collins said that 'the scheme as operated is not providing the safety net promised by ministers and is not in accordance with section 10 [of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012* (UK)] in that it does not ensure the applicants' human rights are not breached or are not likely to be breached'.⁷⁴⁸ The case was brought by the Official Solicitor of England and Wales, who was represented by the legal charity Public Law Project. In response, the government passed the *Civil Legal Aid (Merits Criteria) (Amendment) (No 2) Regulations 2015* (UK).

Reflections

Provided the personal qualities, motivation and attitudes of the lawyers are good and the lawyers are not pressured to take on more cases than they have time to properly handle, being on a fixed salary facilitates high-quality, client-focused legal services because considerations of funding and profit cannot influence or dictate the legal advice or service provided. However, depending on the jurisdiction and particular service model, those two preconditions may not necessarily exist.

I worry how long the goodwill of mental health lawyers in England to provide high-quality services can remain in the face of their need to make a profit to survive, especially if there are further funding cuts and restrictions. It seems unreasonable for a State to fund cases at such a low level that it places individual lawyers in the position of having to choose between providing quality assistance to a person in front of them who desperately needs their help (and to which they are most likely entitled under human rights law) and giving up their free time in order to provide that service properly.

Conclusion

Throughout this report, I have explored how lawyers can act to protect the human rights of people with disabilities who are detained in closed environments for compulsory treatment. However, this chapter demonstrates that simply having a lawyer is not good enough; not only does that lawyer need to possess certain qualities and attitudes, they need to be working within an environment and funding model that facilitates high-quality and effective legal services. In Michael Perlin's opinion, a bad lawyer or one picking up only the occasional, ad hoc matter and who does not provide rights-focused representation may be worse than no lawyer at all.

The search for a single 'best practice' or model legal service is perhaps naive. Each organisation is necessarily a product of its founding legislation, funding conditions and/or *raison d'être*; not all are designed as their directors would choose if they had the power to do so. Furthermore, whether an organisation is functioning optimally to protect the human rights and dignity of its clients cannot be considered in isolation from its local context and how it fits within the sector. For instance, if there is another agency already mandated to provide a particular service to the common client group, it makes sense to develop expertise in a different form of advocacy and direct your resources into different services to help fill in the legal needs gaps.

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Ben Hoare Bell Solicitors & Ors, R (On the Application Of) v The Lord Chancellor [2015] EWHC 523 (Admin). However, Richard Charlton noted that the new regulations – *Civil Legal Aid (Remuneration) (Amendment) Regulations 2015* (UK) – are almost as bad.

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Howard League for Penal Reform and Prisoners' Advice Service, R (on the application of) v The Lord Chancellor [2015] EWCA Civ 819. The applicants' primary contention was that 'removing the seven categories of [prison law cases] entirely from the scope of criminal legal aid renders the system inherently unfair because, in some circumstances, the prisoners affected by these types of decisions will only be able to effectively participate in the decision making process if they are legally represented [due to] the combined consequence of the nature of the prison population, which includes some of the most vulnerable members of society and where those with mental health and learning difficulties are significantly over-represented, and the fact that prisoners live in a closed world which significantly inhibits their ability to access outside sources of free advice' (at [22]). Sir Brian Leveson P, with whom the other Lord Justices agreed, noted, at [17], that 'the authorities recognise that a court may declare a government policy unlawful where it gives rise to an unacceptable risk of unlawful decision making' and, at [25], 'I am prepared to accept that there could be a significant number of individuals subject to these types of decisions for whom it may be very difficult to participate effectively without support from someone. It is arguable, therefore, that without the potential for access to appropriate assistance, the system could carry an unacceptable risk of unfair, and therefore unlawful, decision making. The question of inherent unfairness concerns not simply the structure of the system which may be capable of operating fairly, but whether there are mechanisms in place to accommodate the arguably higher risk of unfair decisions for those with mental health, learning or other difficulties which effectively deprive them of the ability effectively to participate'.

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Pursuant to s 10 of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012* (UK), the director of the legal aid agency may make an 'exceptional case determination' and provide funding for a case that would not otherwise fall within the guidelines if the director determines:

- 'that it is necessary to make the services available to the individual under this Part because failure to do so would be a breach of –
 - 'the individual's [ECHR] rights (within the meaning of the Human Rights Act 1998), or
 - 'any rights of the individual to the provision of legal services that are enforceable EU rights, or
- 'that it is appropriate to do so, in the particular circumstances of the case, having regard to any risk that failure to do so would be such a breach'.

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IS v The Director of Legal Aid Casework & The Lord Chancellor [2015] EWHC 1965 (Admin), [106].

748

Ibid [107].

One of the things I was most pleased to discover during my travels was how well my colleagues at MHDL compare to the high-quality lawyers I encountered overseas. We have the right foundations and personnel to deliver a very effective legal service. However, the existing stressors on our work are significant and potentially unsustainable. Therefore, notwithstanding that some features such as a legislative mandate are not immediately replicable, the operational and service model factors identified in this part are worth close consideration when reflecting on the design and delivery of mental health legal services in Victoria.

RECOMMENDATIONS AND IDEAS

- ▶ Reflect on the working conditions, service model and funding of MHDL to explore opportunities for improvement.
- ▶ Develop a strategy to manage workload and reduce pressure on individual lawyers to deliver services beyond their capacity.
- ▶ Through internal and external consultation, explore alternative solutions to deal with unmet legal need.
- ▶ Consider establishing a national mental health lawyers' association and other opportunities for peer support.

5B. EFFORTS TO REGULATE AND IMPROVE THE QUALITY OF MENTAL HEALTH LAWYERS AND LEGAL SERVICES IN ENGLAND

Concerning practices giving rise to need for regulation

As noted above, the people I met in England – who all care about this work and the people affected by it – spoke about the variable quality of mental health legal services being provided. A particular concern was that unmotivated lawyers do not properly prepare their matters (despite ‘90% of the case [being] preparation’⁷⁴⁹). For instance, Aswini Weeraratne QC, who has sat as an MHT judge since 2001, said that there was a time when advocates would come from far afield to hearings in London and not spend much time with the people they were representing, resulting in poor quality advocacy. Some firms also rely on paralegals or barely qualified lawyers to prepare cases, despite the actual appearance being done by an accredited panel member (see ‘Law Society’s accreditation scheme and guidance’ below).⁷⁵⁰

Dr Richard Noon, the clinical director of the Sussex Partnership NHS Foundation Trust, also described the variable quality of the legal representation he sees in his role as an MHT psychiatrist member sitting in three counties. He said the advocates appearing were often quite junior lawyers or even non-lawyers,⁷⁵¹ indicating that the work was not well respected within their firms, and that the lawyers did not always know what they were doing despite being accredited. He said he finds it frustrating when, as an MHT member, he sees really poor quality evidence being provided by a service and wants the lawyer to ‘go to town’ on them and they do not.

Worse still than this inexperience, ignorance and disinterest, a number of people I spoke with also mentioned underhanded practices by a small minority of unscrupulous lawyers. These included poaching clients, signing up clients without instructions, unrealistically raising a client’s expectations, getting ‘inside’ referrals from staff and inducing clients to sign up with them through unrealistic or bad advice or in exchange for things like cigarettes or phone cards.⁷⁵² A desire to make a profit can drive bad legal advice because of the lawyer’s conflicting financial interest in the matter. For instance, a lawyer may encourage a patient to put in an appeal to the MHT even if it has no prospects of success, which will unreasonably and unhelpfully raise their hopes, simply because the lawyer will get paid to conduct it. One psychiatrist noted that lawyers may even fuel their clients’ psychopathology by encouraging clients (especially those with personality disorders) who ‘feel attacked’ by the system to repeatedly appeal to the MHT to ‘persistently demonstrate their misfortune’.

Principally as a result of the concerns about the quality of advocacy, a number of schemes have now been implemented to regulate and improve the quality of lawyers and legal services undertaking mental health work in England. These include:

- The Law Society’s accreditation scheme and guidance;
- Legal Aid Agency contract requirements;
- Peer review; and
- The MHLA.

Law Society’s accreditation scheme and guidance

The first accreditation scheme and panel of specialist lawyers established by the Law Society back in 1984 was for mental health work: ‘Even back in the 1990s [mental health law] was perceived as very specialised, complex and ethical work, requiring personal maturity’.⁷⁵³

In response to concerns about quality, additional, stricter requirements to apply for panel membership were introduced from September 2014. To join the panel, applicants must now have ‘undertaken a substantial amount of mental health casework for a duration of at least six months within the 12 months prior to their application’⁷⁵⁴ and ‘gained at least six CPD hours in [that] year in the subject area of mental health, or related areas such as mental capacity, community care and human rights’.⁷⁵⁵ Applicants must also complete a compulsory, two-day training course prior to applying (which was the course I undertook in London on 1-2 June 2015). Some of the participants in the course noted how difficult it was for them to meet the casework requirements prior to them gaining accreditation.

⁷⁴⁹ Tam Gill.

⁷⁵⁰ Sheena Ebsworth.

⁷⁵¹ Also Tam Gill. It is possible to be accredited on the Law Society mental health panel even if you are not a lawyer, provided the criteria for accreditation are met; see application form available at <<http://www.lawsociety.org.uk/Support-services/Accreditation/documents/mental-health-initial-application-form/>>.

⁷⁵² Jonathan Wilson, Tam Gill, Sheena Ebsworth.

⁷⁵³ Richard Charlton

⁷⁵⁴ Law Society, *Mental health accreditation application and re-accreditation application forms, guidance notes and policies* (September 2015) 3.

⁷⁵⁵ Ibid 7.

Applicants for accreditation must also be able to demonstrate the following competencies:

- 'Knowledge of the law and procedure which is essential to representing clients before the First-tier Tribunal;
- 'Ability to prepare and present cases effectively for clients in proceedings before the First-tier Tribunal;
- 'Sufficient knowledge of those areas of law, such as mental capacity, community care and human rights, which are relevant to advising and representing clients in proceedings before the First-tier Tribunal;
- 'Sensitivity to and awareness of the particular difficulties clients may face because of mental disorder and by virtue of being subject to [MHA] powers;
- 'Commitment to representing clients with mental disorder; and
- 'Adherence to the ongoing requirements of Law Society Accreditation Scheme Membership and to the Mental Health Accreditation Scheme Code of Practice [see below].'⁷⁵⁶

Finally, applicants must complete a two hour assessment comprising a case study, a multiple choice questionnaire and an interview with a panel of two assessors who examine their practice and professional conduct.⁷⁵⁷

As at 1 October 2015, there were 561 accredited members on the mental health panel in England and Wales.⁷⁵⁸

The Law Society has produced a Mental Health Accreditation Scheme Code of Practice,⁷⁵⁹ which accredited members are required to follow. Among other things, this code states that, when representing a party before the MHT, the lawyer must 'not normally delegate the preparation, supervision, conduct or presentation of the case, but... deal with it personally'.⁷⁶⁰ This aims to prevent firms from using non-accredited people to do the bulk of the work in the name of someone who is accredited, as well as to ensure continuity of service for clients. The code also requires lawyers to abide by the Law Society's practice note on representation before the MHT, which was updated in January 2015.⁷⁶¹

Legal Aid Agency contract requirements

In response to concerns raised by the MHT and the Law Society about quality,⁷⁶² the Legal Aid Agency made it a requirement under the Standard Civil Contract from 1 August 2014 that all advocates appearing before the MHT be members of the Law Society's accreditation scheme.⁷⁶³ Furthermore, the contract requires at least one 'supervisor', who is subject to prescriptive legal competence standards specified in the contract,⁷⁶⁴ be employed for every four caseworkers.⁷⁶⁵

This new requirement saw a big jump in the number of lawyers applying for mental health accreditation scheme membership recently, and a corresponding increase in failure rate (50% up from 40%).⁷⁶⁶

Prior to August 2014, there was a separate tender process for mental health legal services at high secure facilities such as Broadmoor Hospital. However, the August 2014 contracts grouped all mental health services together so that anyone with a contract for mental health work can now undertake it at high secure facilities as well. As a result, there are now about 20 firms on the list for Broadmoor,⁷⁶⁷ up from only five specialist firms when the work was governed by a separate contract.⁷⁶⁸ MHA administrator Sheena Ebsworth noted that, while the accreditation scheme membership requirement has probably improved the quality of legal services in other hospitals, this change in contracting approach has resulted in a lower bar for Broadmoor, with a commensurate drop in the consistency and quality of the lawyers providing services there as they do not yet understand the hospital or its practices. Tam Gill also expressed concern about this change in contracting approach which has resulted in lawyers without experience in forensic mental health matters blithely stepping in and mishandling high-stakes matters.

⁷⁵⁶
Ibid 3.

⁷⁵⁷
Ibid 8-9.

⁷⁵⁸
Full list available at
<www.lawsociety.org.uk/support-services/accreditation/documents/mental-health-members-list>.

⁷⁵⁹
Law Society, *Mental Health Accreditation Scheme Code of Practice* (2011), available at
<www.lawsociety.org.uk/support-services/accreditation/documents/mental-health-code-of-practice>.

⁷⁶⁰
Ibid [1].

⁷⁶¹
Law Society, *Practice Note*, above n 185.

⁷⁶²
Richard Charlton.

⁷⁶³
Unless they are self-employed counsel:
Legal Aid Agency, *2014 Standard Civil Contract Mental Health Specification*, above n 181, [7.6(b)].

⁷⁶⁴
Ibid, [7.9]-[7.13].

⁷⁶⁵
Ibid, [7.6(c)].

⁷⁶⁶
Tam Gill.

⁷⁶⁷
Sheena Ebsworth.

⁷⁶⁸
Tam Gill.

The MHLA... has 'gone from strength to strength' [since its inception in 2000].

– English lawyer Richard Charlton

Peer review

The Legal Aid Agency uses an independent peer review system to assess and ultimately enhance the quality of legal work carried out with public funding.⁷⁶⁹ It was 'introduced to address the lack of substantive legal assessment of files, in contrast with the 'tick-box' approach of compliance audits'.⁷⁷⁰

Peer reviewers are experienced legal aid practitioners. They assess a random sample of a[nother] provider's case files using a standard criteria and ratings system. The peer reviewer writes a detailed report containing their findings including positive areas, areas for improvement and the overall quality rating [ranging from 'excellence' to 'failure in performance'].⁷⁷¹

Based on their collective findings, peer reviewers produced a 41 page guide⁷⁷² to assist lawyers to identify and address common issues which impact on the quality of their service.

Mental Health Lawyers Association

As noted above, the MHLA was formed in 2000. It represents the interests of mental health lawyers rather than representing the interests of their core client group (as other agencies like MIND do that),⁷⁷³ and works to increase the profile of and respect accorded to their work:

We are committed to maintaining the highest level of professionalism in representing our clients. This consists of constant updating of developments in Mental Health Law and also discussions and the sharing of information about practice before [MHTs] across the country. We are also committed to raising the profile of Mental Health Lawyers as a group of professionals who deal with an interesting but highly demanding client group.

We maintain contact with the Law Society, the Legal Services Commission and the Tribunals Service and other interested parties to facilitate the exchange of information to best serve the interests of our clients.⁷⁷⁴

The MHLA was chaired by Richard Charlton from its inception until 2014, when he became its president. He says that it has 'gone from strength to strength' in that time. The MHLA committee comprises a 'rotating core' of highly committed lawyers, who each volunteer their time 'because we believe in it'.⁷⁷⁵ It now has specific subcommittees to focus on particular issues like legal aid, education/training, peer guidance and Court of Protection work.

The MHLA now has a sufficient profile to be consulted on and able to seek conferences with key actors. For instance, it has regular meetings with the Legal Aid Agency, the Law Society and the MHT, at which it will raise systemic practice issues that members report.⁷⁷⁶ It also prepares submissions and comments on proposed legislation on behalf of members.

The MHLA also provides significant training and professional development to the profession. This function has 'grown very considerably in the last few years'.⁷⁷⁷ The MHLA has produced a Code of Conduct,⁷⁷⁸ which (since 2008) members must undertake to follow. Much of the Code of Conduct is directed at preventing touting for business in hospitals, client poaching and improperly influencing clients with regards to legal representation.

⁷⁶⁹ Legal Aid Agency, *Independent Peer Review Of Legal Advice and Work Final Process Paper* (2013) 4.

⁷⁷⁰ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 111 (emphasis in original).

⁷⁷¹ Legal Aid Agency, 'Legal Aid Agency audits' (October 2015) <<https://www.gov.uk/guidance/legal-aid-agency-audits>>. For more information about the peer review process, standard criteria and ratings system, see Legal Aid Agency, *Independent Peer Review Of Legal Advice and Work Final Process Paper*, above n 769.

⁷⁷² Independent Quality Assessment of Legal Services, *Mental Health: Improving your quality – A guide to common issues identified through peer review* (3rd edition, 2011).

⁷⁷³ Tam Gill, Richard Charlton.

⁷⁷⁴ MHLA, 'The MHLA' <<https://www.mhla.co.uk/about/about-the-mhla/>>.

⁷⁷⁵ Tam Gill.

⁷⁷⁶ Ibid.

⁷⁷⁷ Richard Charlton.

⁷⁷⁸ MHLA, *Code of Conduct* (version 2, 2013).

Impact of efforts to improve quality

Richard Charlton and Peter Edwards thought that increased specialisation brought about through the specific practice area contracts has improved the quality and consistency of mental health legal work generally.

There were mixed views regarding the extent to which the requirement for people appearing before the MHT under legal aid contracts to be accredited has improved the quality of legal practice. Richard Charlton said he had not ‘seen an enormous difference’ since the panel accreditation requirements, while Aswini Weeraratne QC felt that the quality of lawyers is starting to improve. In contrast, John O’Donnell, who is also a Law Society panel assessor, felt that the standards may actually have gone down. He believes the standard to be accredited is too easy. In particular, he noted that the accreditation process does not assess whether the lawyer understands mental illness or is able to take instructions from a client. John would like to see a probationary period after lawyers pass the assessment, during which peer assessment takes place in MHT hearings, but the Law Society has rejected this proposal on the basis that it would be too expensive.

Law Society accreditation scheme panel members have to apply for reaccreditation every three years. Tam Gill, who is a Law Society panel assessor as well as the director of her own legal practice specialising in mental health work, said that the pass rate for reaccreditation is about 60%, which means that 40% of lawyers who had been practising immediately prior to applying for reaccreditation did not meet the required standard.

Reflections and conclusion

As England’s experience shows, particularly where there are funding pressures, the quality of mental health legal services depends on appropriate regulations and the establishment of structural supports and conditions that allow them to flourish. There are currently no specific restrictions or practice standards in place governing mental health legal services in Victoria. This absence has not negatively impacted on the quality of mental health legal services in Victoria to date, as almost all services have been provided by a small cohort of specialist lawyers at VLA and the MHLC; very few private lawyers have sought to be involved in this work.⁷⁷⁹ However, noting what happened in England, this may change.

Given the increasing restrictions on the availability of other grants of legal assistance, Victorian private lawyers may similarly turn to the currently untapped potential of the mental health legal assistance guideline to augment their practice and income. This could result in a similar influx of inexperienced practitioners – who do not necessarily possess the skills, knowledge and personal qualities required for high-quality mental health legal work – to the currently unregulated field. Accordingly, rather than risk exposing people to poor quality services, it would be prudent to pre-emptively develop specific protocols and practice standards to make sure that anyone providing mental health legal services in Victoria does so at a high standard.

RECOMMENDATIONS AND IDEAS

- ▶ Consider regulating and/or setting practice standards for the provision of mental health legal services pursuant to grants of legal assistance.

⁷⁷⁹ Private lawyers provided representation in 29 MHT hearings (less than 1%) in 2014-2015: MHT (Victoria), *2014/2015 annual report*, above n 15, 26; only one private lawyer sought a grant of legal assistance from VLA for MHT representation in 2014-2015.

CHAPTER 6:

LOOKING BACK AND LOOKING FORWARD

Looking back: overall reflections

Two weeks before the end of the formal research period of this project, on 14 August 2015, I participated in a MDAC staff enrichment day. Towards the end of the day, a facilitator from Kitchen Budapest (an innovation lab and incubator for start-ups) presented this quote by US Professor Andrew Hargadon:⁷⁸⁰ 'Innovation is about connecting, not inventing'.

Having spent the preceding months in search of innovative legal services, this struck me as particularly pertinent. In the original source, Hargadon explains further:

Innovation is about the difference between an idea that quietly dies and the same idea, in another's hands, that changes companies and industries... No idea will make a difference without building around it the networks that will support it as it grows, and the network partners with which it will ultimately flourish... In other words, innovation has two sides: creativity and entrepreneurship. The creativity lies in conceiving of new possibilities, while entrepreneurship describes turning those new possibilities into realities.⁷⁸¹

This fellowship has provided me with a unique opportunity to conceive of new possibilities for mental health and disability legal services in Victoria. I was able to travel to other jurisdictions to learn about their laws, see first-hand how their legal services are provided, speak to a wide range of participants in the various legal and service systems about the strengths, weaknesses and challenges they face, and learn at least a little about the context in which those services and laws operate. I could then compare what I had learnt with my own experiences of the Victorian mental health and disability legal systems. Differences and, consequently, possibilities quickly emerged.

If you spend each day with your head down, running from case to case, it is easy to forget that the laws and frameworks in which you operate are not universal, absolute or a given. Once you step away from your own system and into another, you notice gaps and anomalies in your own system and are prompted to question matters which you had previously taken for granted. For instance, why is it that rates of legal representation in mental health hearings are so much lower in Victoria than in certain other, ostensibly similar, jurisdictions? Why are CTOs used at vastly higher rates in Victoria compared to those jurisdictions?⁷⁸² These and many more questions arose during my research, which highlighted the ways in which Victoria is out of step with other jurisdictions. Some questions I was able to explore in this report but many others that I collected were beyond the scope of the report. I am nevertheless grateful that I am now equipped with the knowledge and contacts to continue this expedition of discovery.

Of course, just because a law or practice is different overseas, it is not necessarily better or desirable for Victoria. Even if it is, the change will not necessarily translate to or be capable of implementation in the Victorian context. My preliminary analysis, conducted within the time constraints of this project, suggests that the recommendations and ideas I have listed at the end of each section of this report may advance the protection of rights of people with disabilities who have been detained in closed environments for compulsory treatment in Victoria. However, the real work now begins to more closely explore the viability and possible implementation of those ideas in practice.

⁷⁸⁰

Hargadon is the Charles J Soderquist Chair in Entrepreneurship and Professor of Technology Management at the Graduate School of Management at University of California.

⁷⁸¹

Andrew Hargadon, Andrew Hargadon, 'What is innovation' (5 December 2010) <<http://andrewhargadon.com/2010/12/what-is-innovation/>>.

⁷⁸²

Victoria has a rate of 98.8 CTOs per 100,000 people, compared to 15.2 in New York and 8.1 in England: Light, above n 49. At the IALMH conference in Vienna in July 2015, there were numerous presentations questioning the efficacy of CTOs, eg: Lisa Brophy, Renata Kokanovic and Claire Tanner, 'Perspectives on Supported Decision-Making and Community Treatment Orders'; Richard O'Reilly, 'Are Community Treatment Orders Really Necessary for Patients on Assertive Community Treatment Teams?'; Richard O'Reilly and Deborah Corring, 'A systematic review of qualitative research on community treatment orders'.

‘Innovation is about connecting, not inventing.’

– US professor Andrew Hargadon

Looking forward: where to from here?

As Hargadon states, in order to turn a possibility into a reality, a network needs to be built around the idea. Notwithstanding that I am well-placed to influence and improve MHDL’s and VLA’s own practices, carrying these ideas forward is bigger task than I, MHDL or VLA can achieve alone. Working in collaboration with others to achieve a shared goal was a key theme which emerged during my research. Indeed, in order to be respectful of human rights and thus achieve the project aim, it is essential to engage with and truly value the unique perspective – an alternative form of expertise – of people with lived experience of the issues at hand.

In the short term, this report will be disseminated to relevant stakeholders to draw on their attention to and discuss with them the issues and ideas that affect their work and/or which are within their control to progress. Key stakeholders include the MHT, VCAT, the Department of Health and Human Services, the Chief Psychiatrist, the Public Advocate, the Senior Practitioner for Disability, the clinical directors of each mental health service and coalitions of service users. However, this is just the beginning.

MHDL seeks to be a leader in this field and it is well placed to do this. However, resource limitations hamper us from pursuing many of the activities that we identify would help to protect our clients’ rights. Moreover, many of the ideas generated through this fellowship would, if pursued, place even greater pressure on our limited resources. These pressures, which most if not all organisations in this sector experience, create an additional imperative for collaboration and innovation. We therefore need to strengthen our efforts to engage with others from whom we can learn and with whom we can collaborate to maximise the chances of achieving change. I hope as a result of this fellowship to establish a coalition of thought and practice leaders across the sector in Victoria to discuss these ideas and progress this work, including:

- People with disabilities and lived experience of compulsory treatment in closed environments;
- Other mental health and disability legal services doing similar work; and
- Non-legal services doing related work, such as advocacy agencies, NGOs and researchers.

As one of the few jurisdictions in Australia with broad statutory human rights protection, Victoria should be a leader in this field. While MHDL currently has very limited contact with its counterparts in other states and territories, there would be mutual benefit in establishing a network of mental health and disability legal services around Australia. As this fellowship demonstrates, even quite different jurisdictions experience similar issues and discussing different approaches can be extremely enlightening, even if local solutions ultimately differ.⁷⁸³

While the task ahead is rather daunting, the recent volume of disability-related inquiries and law and policy reform suggests we are currently in an environment which is more receptive to ideas about disabilities rights. I am hopeful that, by working together, we can build momentum for real and lasting improvements to strengthen the protection of human rights of people with disabilities who are detained in closed environments for compulsory treatment.

RECOMMENDATIONS AND IDEAS

- ▶ Meet with key stakeholders and, if there is interest, establish a coalition of thought and practice leaders across the mental health and disability rights sector in Victoria to discuss the ideas arising from this fellowship and to collaborate in progressing this work.
- ▶ Establish a network of mental health and disability legal services across Australia to share practice experience, explore law reform ideas and facilitate professional development.

⁷⁸³ ‘Organisations should make every effort to learn about other lawyering organisations and [NGOs], even when the mandates or constituencies are distinct’: Wilson and Rasmussen, above n 498, 90.

APPENDICES

APPENDIX 1: VLA AND MHDL

Victoria Legal Aid ('VLA') is an independent statutory authority that provides free and affordable legal help to Victorians, particularly those who are socially and/or economically disadvantaged. It provides grants of legal assistance to people who meet the eligibility guidelines in relation to certain criminal, family and civil law matters. It also has a significant in-house legal practice, with over 400 FTE staff involved in direct service delivery.⁷⁸⁴

VLA is funded by the Commonwealth (Australian) and Victorian governments but operates independently of government.

While VLA has been providing mental health legal services for many years, the Mental Health and Disability Law sub-program ('MHDL') was not formally established until 2011. MHDL sits within VLA's Civil Justice program, alongside the migration, Commonwealth entitlements, equality law and social inclusion sub-programs.

MHDL's aim is to ensure that the rights of persons with disability are respected and that any restrictions on those rights are demonstrably necessary and cause minimum interference. We advocate for decision-makers such as courts, tribunals and clinicians to apply laws correctly, conduct fair hearings, make evidence-based decisions and genuinely take into account the person's views and wishes when deciding whether to restrict the rights of a person with a disability.

There are currently 15 lawyers (12.6 FTE) employed exclusively in MHDL, but other lawyers and staff throughout VLA also contribute to the work of the program.

Areas of law and core client group

MHDL's core work involves assisting people who are, or are at risk of being, subjected to involuntary detention, supervision and/or treatment due to the alleged risks they pose to themselves or others because of their disabilities. MHDL also assists people who have had, or are at risk of having, their decision-making rights taken away due to their alleged incapacity to make certain decisions, such as where to live and how to manage their money.

These legal matters arise under the *Mental Health Act 2014* (Vic), the *Disability Act 2006* (Vic), the *Guardianship and Administration Act 1986* (Vic), the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) and the *Severe Substance Dependence Treatment Act 2010* (Vic) (for an explanation of the mental health laws, see Appendix 3 below). The *Charter of Human Rights and Responsibilities Act 2006* (Vic) is also highly relevant to our work.

All of MHDL's clients have been diagnosed with or are alleged to have a mental illness, intellectual disability and/or neurological disability. They typically experience additional forms of social disadvantage as well. As a result, many of our clients experience a range of complex, interconnected social and legal issues. We aim to assist them with these issues as holistically as possible through our own services and referrals to external services.

⁷⁸⁴
VLA, *Annual report 2014-15*, above
n 236, 67.

Services and work types

Legal advice and information

MHDL provides specialist legal advice through a free, state-wide telephone service, from 8:45am to 5:15pm on weekdays. People can also make an appointment to meet face to face with a lawyer at one of our 14 offices around the state.

In addition, we provide free outreach legal advice services at almost all psychiatric units in Victoria where people are detained for compulsory treatment. Each unit is serviced by a particular lawyer who will typically attend there once or twice a week. The lawyer will offer advice to anyone with a hearing scheduled before the Mental Health Tribunal (**'MHT'**) and provide advice to anyone else requesting legal assistance.

Duty lawyer services

MHDL's duty lawyers provide free legal representation for many people at the MHT, which conducts hearings in relation to compulsory psychiatric treatment at dozens of hospitals and community mental health services across the state (see 'Mental health hearings before the MHT' in Appendix 3 below).

Case work

MHDL provides ongoing legal assistance to eligible clients through file work and legal representation before the MHT, the Victorian Civil and Administrative Tribunal (**'VCAT'**), the Forensic Leave Panel, the County Court and the Supreme Court. We also advocate on behalf of our clients to other administrative decision-makers, such as psychiatrists, disability service managers and appointed guardians.

We always act on our clients' instructions, rather than in what others perceive to be their best interests.

Strategic advocacy and law reform

VLA is obliged under its founding legislation, the *Legal Aid Act 1978* (Vic), to seek innovative means of providing legal assistance to reduce the need for individual legal services. We are also required to provide the community with improved access to justice and legal remedies. One way of achieving this is by pursuing improvements in law and policy that result in better outcomes for our clients and the community more broadly.

MHDL is committed to working on the justice system as well as within it. We advocate for justice and law reform where we see the law and legal processes impacting disproportionately or unfairly on the people we work with. Our justice and law reform activities include:

- Running test cases to clarify points of law;
- Making submissions to inquiries and reviews; and
- Advocating directly to government and the courts to improve policies and processes.

We also provide legal education in a range of formats to help build knowledge in the community about legal rights and responsibilities. Our focus is on early intervention to prevent legal problems from arising or escalating. For example, we are currently working with the Department of Education and Early Childhood Development to produce an e-based education kit for high school teachers of students with intellectual disability, to educate students about common legal issues and how to get help.⁷⁸⁵

⁷⁸⁵
See VLA, 'Learning the law'
<<http://www.legalaid.vic.gov.au/about-us/community-education-and-projects/learning-law>>.

APPENDIX 2: FELLOWSHIP RESEARCH PROGRAM

The dates indicate when I first met or substantively communicated with the person.

An asterisk indicates that substantive discussion also occurred on other dates.

All interviews were conducted in person unless otherwise indicated.

Date	Person/organisation/event	Research activity
New York, US		
4 May 2015*	Michael Perlin Emeritus Professor New York Law School Also the first director of the Division of Mental Health Advocacy in the New Jersey Office of the Public Defender, from 1974 to 1982	Interview
5 May 2015*	Alison J. Lynch, Esq. Staff Attorney Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program Disability Rights New York	Interview
6 May 2015*	Naomi Weinstein Senior Attorney First Department Mental Hygiene Legal Service	Interview
6 May 2015	Bronx Psychiatric Center	Tour/observation
6 May 2015	Supreme Court mental health hearings at the Bronx Psychiatric Center	Observation and discussions with staff and judge
7 May 2015	Supreme Court mental health hearings in the formal courthouse in Brooklyn	Observation
7 May 2015*	Sara Rollyson Principal Attorney Kings County Office, Brooklyn Second Department Mental Hygiene Legal Service	Interview
8 May 2015	Mallory Curran Supervising Attorney (<i>at time of interview</i>) Mental Health Law Project MFY Legal Services, Inc.	Interview
12 May 2015*	Tina Minkowitz President Center for the Human Rights of Users and Survivors of Psychiatry	Correspondence

Date	Person/organisation/event	Research activity
19 May 2015	<p>Lisa Furst</p> <p>Director of Public Education at the Center for Policy, Advocacy and Education and Director of Education for the Geriatric Mental Health Association of New York City</p> <p>Martin Blair</p> <p>Director of Communications Mental Health Association of New York City</p>	Joint interview
20 May 2015*	<p>Michael Neville</p> <p>Director Second Department Mental Hygiene Legal Service</p> <p>Lisa Volpe</p> <p>Principal Attorney-in-Charge Special Litigation and Appeals Unit Second Department Mental Hygiene Legal Service</p>	Joint interview
20 May 2015*	<p>Jota Borgmann</p> <p>Senior Staff Attorney Disability and Aging Rights Project (formerly Adult Homes Advocacy Project) MFY Legal Services, Inc.</p>	Interview
21 May 2015*	<p>Mark Murphy</p> <p>Director Protection and Advocacy for Individuals with Mental Illness (PAIMI) program Disability Rights New York</p> <p><i>All views expressed are his own and do not necessarily reflect DRNY's</i></p>	Interview
14 July 2015*	<p>Jennifer Monthie</p> <p>Director Protection and Advocacy for Individuals with Intellectual and Developmental Disability (PADD) program Disability Rights New York</p>	Correspondence
16 Aug 2015*	<p>Katherine McCabe</p> <p>Volunteer lawyer Second Department Mental Hygiene Legal Service</p> <p>Previously worked as a mental health lawyer in England</p>	Skype interview
Washington DC, US		
12 May 2015*	<p>Ira Burnim</p> <p>Legal Director Judge David L. Bazelon Center for Mental Health Law</p>	Interview

Date	Person/organisation/event	Research activity
15 May 2015	Kimberly Clark Managing Attorney Mental Health Division Washington DC Public Defender Service	Interview
15 May 2015	Jennifer Bellamy Lobbyist American Civil Liberties Union	Interview
17 May 2015	St Elizabeths Hospital 'family and friends day'	Tour/observation and discussions with staff, peer advocates and patients
17 May 2015	Yvonne Smith Peer advocate	Interview
18 May 2015	Laurie Ahern President Disability Rights International Eric Rosenthal Executive Director Disability Rights International	Interviews
New Jersey, US		
14 May 2015	Patrick Reilly Director Division of Mental Health Advocacy New Jersey Office of the Public Defender	Telephone interview
20 May 2015	Lycette Nelson Former Litigation Director at Mental Disability Advocacy Centre; now has her own firm in New Jersey	Interview
England		
1-2 June 2015	Two-day course for membership of the Law Society's Mental Health Accreditation Scheme Presented by the Mental Health Lawyers Association, London	Course
2 June 2015	Jonathan Wilson Consultant solicitor Switalskis Solicitors, West Yorkshire Author/administrator of 'Mental Health Law Online' website ⁷⁸⁶ Mental Health Lawyers Association committee member	Interview
4 June 2015	'Public law in an age of austerity' Hosted by One Crown Office Row (barristers' chambers) and JUSTICE, London	Seminar

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See
<<http://www.mentalhealthlaw.co.uk/>>.

Date	Person/organisation/event	Research activity
5 June 2015	Hellingly Centre (medium secure mental health facility), Hailsham, East Sussex	Tour/observation and discussions with staff
5 June 2015	Dr Richard Noon Clinical Director Sussex Partnership NHS Foundation Trust Mental Health Tribunal psychiatrist member	Interview
5 June 2015	Tam Gill Director Gledhill Solicitors, Brighton Mental Health Lawyers Association Vice-Chair Law Society Assessor for the Mental Health Accreditation Scheme Independent Funding and Costs Adjudicator for Legal Aid Agency	Interview
11 June 2015*	Dr Lucy Series Research Associate Cardiff Law School Cardiff University Author of 'The Small Places' blog ⁷⁸⁷	Correspondence and skype interview
15 June 2015*	Aswini Weeraratne QC Barrister and team leader Mental Health and Court of Protection Team Doughty Street Chambers Mental Health Tribunal judge	Telephone interview
15 June 2015	John O'Donnell Senior Partner O'Donnells solicitors, Preston, Lancashire Mental Health Lawyers Association committee member Law Society Assessor for the Mental Health Accreditation Scheme	Interview
16-19 June 2015	International Association of Forensic Mental Health Services (IAFMHS) conference, Manchester	Conference and discussions with numerous delegates
18 June 2015*	Ian Callaghan Recovery and Outcomes Manager Rethink Mental Illness Also a service user with lived experience and the UK National Service User Lead for a recovery and outcomes-focused initiative called 'My Shared Pathway'	Interview and correspondence

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See
<<https://thesmallplaces.wordpress.com>>.

Date	Person/organisation/event	Research activity
17 June 2015	Neil Allen Barrister 39 Essex Chambers Academic University of Manchester	Interview
19 June 2015	Broadmoor Hospital (high secure mental health facility), Crowthorne, Berkshire	Tour/observation and discussions with staff
19 June 2015*	Sheena Ebsworth MHA and Records Manager Broadmoor Hospital	Interview
19 June 2015	Dr Samrat Sengupta Consultant Psychiatrist Broadmoor Hospital	Interview
22 June 2015	Alex Ruck Keene Barrister 39 Essex Chambers Academic Author/administrator of 'Mental Capacity Law and Policy' website ⁷⁸⁸	Interview
22 June 2015	Mental Health Tribunal sitting at Burnley General Hospital, Lancashire	Observation and discussions with staff
23 June 2015	Richard Charlton Richard Charlton Solicitors, Folkestone, Kent Mental Health Lawyers Association President	Interview
23 June 2015*	Sophy Miles Barrister Doughty Street Chambers Fee-paid First Tier Tribunal (Mental Health) judge Chair of Law Society Mental Health and Disability committee Co-author of <i>Mental Health Tribunal Handbook</i> (2015) <i>All views are in her personal capacity</i>	Interview
24 June 2015	Ana Aiello PhD Candidate Leeds University	Interview
24 June 2015	Professor Geneva Richardson The Dickson Poon School of Law Kings College London	Interview

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See
<<http://www.mentalcapacitylawandpolicy.org.uk>>.

Date	Person/organisation/event	Research activity
25 June 2015	Mental Health Tribunal sitting at Warrington Hospital, Cheshire	Observation and discussions with staff
25 June 2015	Peter Edwards (and staff Jenny Oxtan, Stephen Beard, Sarah Edwards) Peter Edwards Law Ltd, Hoylake, Wirral Mental Health Lawyers Association committee member	Interview
18 Aug 2015	Emma Norton Lawyer Liberty	Skype interview
12 Aug 2015*	Sue Eades Manager of IMHA services for Broadmoor seAp (support, empower, advocate, promote)	Skype interview
Vienna, Austria		
13-17 July 2015	International Academy of Law and Mental Health (IALMH) conference	Conference and discussions with numerous delegates
Budapest, Hungary		
23 July 2015	Dr Adrienn Gazsi Lawyer KézenFogva Alapítvány (Hand in Hand Foundation)	Interview
13 Aug 2015*	Tamás Verdes Head of the Disability Rights Program Társaság A Szabadságjogokért (Hungarian Civil Liberties Union)	Interview
29 June – 28 Aug 2015	Mental Disability Advocacy Centre	Observation and discussions during six weeks' volunteer work ⁷⁸⁹
10 July 2015*	Oliver Lewis Executive Director Mental Disability Advocacy Centre	Interview
19 Aug 2015*	Ann Campbell Litigation Director Mental Disability Advocacy Centre	Interview
26 Aug 2015	Reménysugár Rehabilitációs Intézet ('Ray of Hope') 116 bed institution for people with multiple and profound disabilities on the outskirts Budapest	Tour/observation and discussions with staff
27 Aug 2015*	Steven Allen Campaigns Director Mental Disability Advocacy Centre	Interview

⁷⁸⁹ Only one week of this was formally part of the Churchill fellowship.

APPENDIX 3: VICTORIAN MENTAL HEALTH LEGAL SERVICES IN CONTEXT

General legal context and rights framework

The Australian Constitution establishes a federal system of government in which powers are distributed between the Commonwealth and the six states. Mental health laws are made by – and therefore vary between – the states.

The Constitution itself provides only very limited rights protection for individuals, however the common law has long recognised and protected various rights.

Victoria is one of the few states or territories in Australia that has a dedicated human rights statute: the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**'Charter'**). The Charter protects certain fundamental human rights (predominantly civil and political rights), which may only be subject to 'such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom', taking into account various factors.⁷⁹⁰

There is no direct cause of action under the Charter for a breach of human rights. However, rights are protected in the following ways:

- Public authorities must not act in a way that is incompatible with human rights and must give proper consideration to relevant human rights when making decisions.⁷⁹¹
- Any new Bill introduced to Parliament must be accompanied by a 'statement of compatibility' explaining the nature and extent of any incompatibility with human rights.⁷⁹²
- Courts must interpret all legislation in a way that is compatible with human rights, so far as it is possible to do so consistently with their purpose.⁷⁹³ If it is not possible to interpret the law in a way that is compatible, the Supreme Court can issue a 'declaration of inconsistent interpretation',⁷⁹⁴ which requires the responsible Minister to review it. The court, however, cannot strike down inconsistent legislation.

Australia ratified the CRPD in July 2008 and its optional protocol in 2009, which allows an individual to petition the CRPD Committee claiming that Australia has breached their Convention rights. At the time it ratified the CRPD, Australia made the following declaration in relation to article 12 (equal recognition before the law):

Australia declares its understanding that the CRPD allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards.

In 2013, the CRPD Committee reviewed Australia's initial report against the CRPD and recommended that Australia review this declaration 'in order to withdraw' it.⁷⁹⁵

Laws relating to the detention and compulsory treatment of people with mental illness: *Mental Health Act 2014* (Vic)

The *Mental Health Act 2014* (Vic) (**'MHA'**), which repeals and replaces the *Mental Health Act 1986* (Vic) and is the culmination of many years of development and consultation by the Victorian government, provides a legislative scheme for the assessment and compulsory treatment of people with mental illness within the public health system. Its framework is intended to promote recovery-oriented practice, minimise compulsory treatment and protect and support the rights of people living with mental illness (see box below).

790 Charter s 7(2). The factors are: (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relationship between the limitation and its purpose; and (e) any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

791 Ibid s 38(1).

792 Ibid s 28.

793 Ibid s 32(1).

794 Ibid s 36.

795 United Nations Committee on the Rights of Persons with Disabilities, *Concluding observations on the initial report of Australia*, 2 [9].

Objectives and principles of the MHA

10 Objectives

This Act has the following objectives—

- (a) to provide for the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness;
- (b) to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity;
- (c) to protect the rights of persons receiving assessment and treatment;
- (d) to enable and support persons who have mental illness or appear to have mental illness—
 - (i) to make, or participate in, decisions about their assessment, treatment and recovery; and
 - (ii) to exercise their rights under this Act;
- (e) to provide oversight and safeguards in relation to the assessment of persons who appear to have mental illness and the treatment of persons who have mental illness;
- (f) to promote the recovery of persons who have mental illness;
- (g) to ensure that persons who are assessed and treated under this Act are informed of their rights under this Act;
- (h) to recognise the role of carers in the assessment, treatment and recovery of persons who have mental illness.

11 The mental health principles

- (1) The following are the mental health principles—
 - (a) persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred;
 - (b) persons receiving mental health services should be provided those services with the aim of bringing about the best possible therapeutic outcomes and promoting recovery and full participation in community life;
 - (c) persons receiving mental health services should be involved in all decisions about their assessment, treatment and recovery and be supported to make, or participate in, those decisions, and their views and preferences should be respected;
 - (d) persons receiving mental health services should be allowed to make decisions about their assessment, treatment and recovery that involve a degree of risk;
 - (e) persons receiving mental health services should have their rights, dignity and autonomy respected and promoted;
 - (f) persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to;
 - (g) persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised and responded to;
 - (h) Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to;
 - (i) children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration, including receiving services separately from adults, whenever this is possible;
 - (j) children, young persons and other dependents of persons receiving mental health services should have their needs, wellbeing and safety recognised and protected;
 - (k) carers (including children) for persons receiving mental health services should be involved in decisions about assessment, treatment and recovery, whenever this is possible;
 - (l) carers (including children) for persons receiving mental health services should have their role recognised, respected and supported.

- (2) A mental health service provider must have regard to the mental health principles in the provision of mental health services.
- (3) A person must have regard to the mental health principles in performing any duty or function or exercising any power under or in accordance with this Act.

Mental illness is defined in s 4(1) of the MHA as 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory'. However, a person may not be considered to have a mental illness by reason only of certain matters, such as having previously been treated for mental illness, having an intellectual disability, or their religious, political or spiritual beliefs.⁷⁹⁶

Process for compulsory treatment under the *Mental Health Act 2014* (Vic)

Initial examination and assessment orders

A registered medical practitioner or 'mental health practitioner'⁷⁹⁷ may make an 'assessment order' in respect of a person if they believe the following criteria are met:

- The person appears to have mental illness;
- Because of this, the person appears to need treatment to prevent serious harm to themselves, serious deterioration in their mental or physical health or serious harm to another person;
- If an assessment order is made, they can be assessed; and
- There is no less restrictive means reasonably available to enable the person to be assessed.⁷⁹⁸

The assessment order must be a community assessment order (ie authorising the assessment to take place in the community), unless they are satisfied that assessment of the person cannot occur in the community, in which case they can make an inpatient assessment order.⁷⁹⁹ If a person is placed on an inpatient assessment order, they must be taken to a designated mental health service within 72 hours. Once they have been received at the service, the inpatient assessment order lasts for up to 24 hours (or up to 72 hours if extended).⁸⁰⁰

Temporary treatment orders

A person on an assessment order must be examined by an 'authorised psychiatrist'⁸⁰¹ as soon as practicable after the assessment order is made or after they have been received at the mental health service.⁸⁰² If the authorised psychiatrist is satisfied that the person meets all of the treatment criteria (see box below), they can make a 'temporary treatment order' ('**TTO**').⁸⁰³

Treatment criteria and other matters which must be considered

The treatment criteria are that:

- (a) 'the person has mental illness; and
- (b) 'because the person has mental illness, the person needs immediate treatment to prevent:
 - (i) 'serious deterioration in their mental or physical health; or
 - (ii) 'serious harm to the person or to another person;
- (c) 'the immediate treatment will be provided to the person if the person is subject to a [TTO] or treatment order; and
- (d) 'there is no less restrictive means reasonably available to enable the person to receive the immediate treatment'.⁸⁰⁴

In deciding whether the treatment criteria apply, as well as having regard to the mental health principles,⁸⁰⁵ the decision-maker must also have regard to all of the following 'to the extent that is reasonable in the circumstances':⁸⁰⁶

- (a) 'the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve;
- (b) 'the views and preferences of the person expressed in his or her advance statement;
- (c) 'the views of the person's nominated person;
- (d) 'the views of a guardian of the person;

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Mental Health Act 2014 (Vic) s 4(2). The full list of matters are that the person:

- (a) Expresses or refuses or fails to express a particular political opinion or belief;
- (b) Expresses or refuses or fails to express a particular religious opinion or belief;
- (c) Expresses or refuses or fails to express a particular philosophy;
- (d) Expresses or refuses or fails to express a particular sexual preference, gender identity or sexual orientation;
- (e) Engages in or refuses or fails to engage in a particular political activity;
- (f) Engages in or refuses or fails to engage in a particular religious activity;
- (g) Engages in sexual promiscuity;
- (h) Engages in immoral conduct;
- (i) Engages in illegal conduct;
- (j) Engages in antisocial behaviour;
- (k) Is intellectually disabled;
- (l) Uses drugs or consumes alcohol [though this provision does not prevent the 'serious temporary or permanent physiological, biochemical or psychological effects of using drugs or consuming alcohol from being regarded as an indication that a person has mental illness': 4(3)];
- (m) Has a particular economic or social status or is a member of a particular cultural or racial group;
- (n) Is or has previously been involved in family conflict;
- (o) Has previously been treated for mental illness.

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A 'mental health practitioner' is any registered psychologist, registered nurse, social worker or registered occupational therapist who is employed or engaged by a designated mental health service: *Mental Health Act 2014* (Vic) s 3(1).

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Mental Health Act 2014 (Vic) s 29.

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Ibid s 30(4).

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The order may be extended up to twice, to a maximum total of 72 hours, but only if the authorised psychiatrist determines on examination that they are not able to decide whether the criteria for compulsory treatment are met: *Ibid* s 34.

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The governing body of a designated mental health service must appoint one or more psychiatrists as the authorised psychiatrist/s for the designated mental health service: *Mental Health Act 2014* (Vic) s 150. The appointed psychiatrist then has all the functions, powers and duties conferred on an authorised psychiatrist by or under the MHA.

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Mental Health Act 2014 (Vic) s 36.

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Ibid s 46. Note that the authorised psychiatrist making the TTO must not have made the assessment order.

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Ibid s 5.

805

Ibid s 11(3).

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For authorised psychiatrists, see *Mental Health Act 2014* (Vic) s 46(2); for the MHT, see s 55(2).

- (e) 'the views of a person's carer, if... [the making of a treatment order] will directly affect the carer and the care relationship;
- (f) 'the views of a parent of the person, if the person is under the age of 16 years, and
- (g) 'the views of the Secretary to the Department of Health and Human Services, if the person is the subject of a custody to Secretary order or a guardianship to Secretary order'.

The TTO must be a community TTO, unless the authorised psychiatrist is satisfied that treatment of the person cannot occur in the community, in which case they can make an inpatient TTO,⁸⁰⁷ which authorises detention and treatment in a designated mental health service.⁸⁰⁸

A TTO lasts for 28 days, unless it is revoked by the authorised psychiatrist or the Mental Health Tribunal ('MHT') sooner.⁸⁰⁹

The MHT and treatment orders

Prior to the expiry of a TTO, the MHT must conduct a hearing to determine whether to make a treatment order.⁸¹⁰ Hearings are described under 'Mental health hearings before the MHT' below.

If the MHT is not satisfied that the treatment criteria apply, it must revoke the TTO. If the MHT is satisfied that the treatment criteria apply (having regard to the above matters), it must make a treatment order.

The treatment order must be a community treatment order ('CTO') unless the MHT is satisfied that treatment of the person cannot occur in the community, in which case it can make an inpatient treatment order ('ITO') (which, like an inpatient TTO, authorises detention and treatment in a designated mental health service).⁸¹¹

The MHT must also specify the duration of the treatment order. For people over 18 years, a CTO can be made for up to 12 months and an ITO for up to six months.⁸¹² If the person is under 18, neither type of order can exceed three months.⁸¹³

If, towards the end of the treatment order, the authorised psychiatrist believes that a further period of compulsory treatment is required, they can apply to the MHT for a further treatment order.⁸¹⁴ The MHT will then conduct another hearing to determine whether to make a further treatment order.⁸¹⁵ There is no limit on the number or total duration of consecutive treatment orders that can be made over a person.

Variation of treatment order setting

An authorised psychiatrist can vary a TTO or treatment order from an inpatient to a community order and vice versa at any time. However, if the variation is to an inpatient order, the authorised psychiatrist must first be satisfied that treatment cannot occur in the community.⁸¹⁶ Within 28 days of a person being varied from a CTO to an ITO, if the person is still on the ITO, the MHT must conduct a hearing to determine whether to make a treatment order or revoke the ITO.⁸¹⁷

Bringing compulsory treatment to an end

The authorised psychiatrist has a statutory obligation to revoke a (temporary) treatment order if they determine that the treatment criteria do not apply to the person.⁸¹⁸

If a person subject to a (temporary) treatment order disagrees with it, they (or someone on their behalf) can apply to the MHT at any time to have the order revoked.⁸¹⁹ The MHT must then hold a hearing as soon as practicable to determine whether to make a treatment order or revoke the current order.⁸²⁰ There is no limit on the number or frequency of revocation applications a person can make.

If, at any hearing, the MHT determines that the treatment criteria are not met, it must revoke the (temporary) treatment order.

⁸⁰⁷ *Mental Health Act 2014* (Vic) s 48(3).

⁸⁰⁸ *Ibid* s 45(1)(b).

⁸⁰⁹ *Ibid* s 51(1). If there are exceptional circumstances, the MHT may extend a TTO for up to 10 business days: s 192.

⁸¹⁰ *Ibid* s 53.

⁸¹¹ *Ibid* ss 52, 55(3).

⁸¹² *Ibid* s 57(2)(a).

⁸¹³ *Ibid* s 57(2)(b).

⁸¹⁴ *Ibid* s 54. They must apply at least 10 business days before expiry of the TTO: s 54(3).

⁸¹⁵ *Ibid* s 54(5).

⁸¹⁶ *Ibid* s 58(2).

⁸¹⁷ *Ibid* s 58(5).

⁸¹⁸ *Ibid* s 61.

⁸¹⁹ *Ibid* s 60.

⁸²⁰ *Ibid* s 60(3).

Challenging an MHT decision

If the MHT makes a decision which the person disagrees with, they can:

- Ask the MHT to provide a written statement of reasons for its decision;⁸²¹
- Apply (again) to the MHT for revocation of the treatment order; and/or
- Apply to the Victorian Civil and Administrative Tribunal ('VCAT') for a 'review' of the decision.⁸²²

The VCAT hearing is conducted 'de novo'. This means that VCAT stands in the shoes of and exercises the same powers as the original decision-maker (the MHT), and so will make the decision afresh, based on current evidence, rather than scrutinising or reviewing the MHT's original decision.⁸²³

Provision of treatment

'Treatment' is defined broadly in the MHA: 'a person receives *treatment* for mental illness if things are done in the course of the exercise of professional skills—

- (i) 'to remedy the person's mental illness; or
- (ii) 'to alleviate the symptoms and reduce the ill effects of the person's mental illness'.⁸²⁴

Notwithstanding that a person is subject to a (temporary) treatment order, before any treatment is administered to them, their informed consent must be sought⁸²⁵ and the person seeking this consent must presume that they have the capacity to give it.⁸²⁶ The MHA provides a definition of 'capacity to give informed consent'⁸²⁷ and sets out some principles to guide the assessment of capacity.⁸²⁸

If the person does not provide informed consent, the authorised psychiatrist may make a compulsory treatment decision in respect of any treatment other than electroconvulsive treatment ('ECT', see below) or neurosurgery for mental illness if satisfied that:

- The person does not have the capacity to give informed consent to the proposed treatment, or has the capacity but has refused;⁸²⁹ and
- There is no less restrictive way to treat the person other than the treatment proposed by the authorised psychiatrist.⁸³⁰

The authorised psychiatrist must have regard to certain factors in deciding whether there is no less restrictive way for the person to be treated, including:⁸³¹

- The patient's views and preferences about treatment of their mental illness and any beneficial alternative treatments that are reasonably available and the reasons for those views and preferences, including any recovery outcomes that the patient would like to achieve;
- The views and preferences expressed in the patient's advance statement;
- The views of the patient's nominated person;
- The likely consequences for the patient if the proposed treatment is not performed; and
- Any second psychiatric opinion that has been given to the authorised psychiatrist.

Electroconvulsive treatment

Prior to July 2014, authorised psychiatrists had the power to decide whether ECT should be administered to an involuntary patient.⁸³² Since then, ECT can only be administered to an adult on a (temporary) treatment order if they provide informed consent or if the MHT grants the authorised psychiatrist's application for compulsory ECT.⁸³³ In order to grant an ECT application, the MHT must be satisfied that:

- The person does not have the capacity to give informed consent; and
- There is no less restrictive way for the person to be treated.⁸³⁴

Any ECT administered to a person under 18 years must be approved by the MHT, even if the person has provided informed consent.⁸³⁵

The MHT must determine the number of ECT treatments which will constitute the course of ECT (up to 12) and the duration within which the course must be completed (up to six months).⁸³⁶ Any further course of ECT must be separately approved by the MHT.

⁸²¹ Ibid s 198. Note that, unlike the English MHT, written reasons are not provided as a matter of course.

⁸²² Ibid s 201.

⁸²³ See *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 51.

⁸²⁴ *Mental Health Act 2014* (Vic) s 6(a).

⁸²⁵ Ibid s 70(1).

⁸²⁶ Ibid s 70(2).

⁸²⁷ 'A person has the *capacity to give informed consent* under this Act if the person—

- (a) 'understands the information he or she is given that is relevant to the decision; and
- (b) 'is able to remember the information that is relevant to the decision; and
- (c) 'is able to use or weigh information that is relevant to the decision; and
- (d) 'is able to communicate the decision he or she makes by speech, gestures or any other means'; *Mental Health Act 2014* (Vic) s 68(1).

⁸²⁸ The principles are:

- (a) 'a person's capacity to give informed consent is specific to the decision that the person is to make;
- (b) 'a person's capacity to give informed consent may change over time;
- (c) 'it should not be assumed that a person does not have the capacity to give informed consent based only on his or her age, appearance, condition or an aspect of his or her behaviour;
- (d) 'a determination that a person does not have capacity to give informed consent should not be made only because the person makes a decision that could be considered to be unwise;
- (e) 'when assessing a person's capacity to give informed consent, reasonable steps should be taken to conduct the assessment at a time at, and in an environment in, which the person's capacity to give informed consent can be assessed most accurately'; *Mental Health Act 2014* (Vic) s 68(2).

⁸²⁹ *Mental Health Act 2014* (Vic) s 71(1).

⁸³⁰ Ibid s 71(3).

⁸³¹ Ibid s 71(4).

⁸³² *Mental Health Act 1986* (Vic) s 73(3), (4).

⁸³³ *Mental Health Act 2014* (Vic) s 92(1).

⁸³⁴ Ibid s 96(1).

⁸³⁵ Ibid s 92(2).

⁸³⁶ Ibid ss 91, 97.

Use of compulsory treatment laws

The MHT made 4912 treatment orders in 2014-2015, of which 53% were CTOs and 47% were ITOs.⁸³⁷ The majority of ITOs (59%) were made for the maximum or close to the maximum possible duration.⁸³⁸ As some people would have been subject to multiple orders within this period, the total number of people subjected to treatment orders would have been fewer than 4912. Information on the number of TTOs made is not available.

Victoria has a rate of 98.8 CTOs per 100,000 people.⁸³⁹

ECT is administered more commonly in Victoria than in many other jurisdictions, with around 4.4 ECT treatments per 10,000 people.⁸⁴⁰ In 2013-2014, 1857 Victorians received almost 22,000 ECT treatments.⁸⁴¹ In 2014-2015, the MHT made 550 orders authorising compulsory ECT.⁸⁴²

Mental health hearings before the MHT

The operation of the MHT is governed by Part 8 of the MHA. To hear cases, the MHT sits as a panel of three: a legal member (who presides), a registered medical practitioner or psychiatrist member,⁸⁴³ and a community member. Travelling divisions of the MHT conduct in-person hearings on a scheduled weekly or fortnightly basis at 56 venues around the state.⁸⁴⁴ In addition, the MHT conducts a significant proportion (29%) of hearings via video-conferencing facilities from its head office.⁸⁴⁵ Each division of the MHT will conduct up to six hearings a day, scheduled at hourly intervals.

In-person hearings are usually conducted in a meeting or seminar room of the mental health service where the patient is being treated. Generally, those present at a hearing, other than the Tribunal members, are the patient and the treating doctor who attends as the representative of the authorised psychiatrist. When a person is on a [CTO,] their case manager will often attend as well – something the [MHT] encourages strongly. In some cases, friends and relatives of the patient also attend.⁸⁴⁶

No party bears an onus of proof, but the authorised psychiatrist is required to prepare and provide a report prior to the hearing addressing the treatment criteria and other matters.⁸⁴⁷

In conducting a hearing, MHT is not bound by the rules of evidence but:

- ‘Is bound by the rules of procedural fairness;
- ‘May inform itself on any matter as it sees fit; and
- ‘Must conduct each proceeding as expeditiously and with as little formality and technicality as the requirements of [the MHA], the regulations and rules and a proper consideration of the matters before it permit’.⁸⁴⁸

The MHT describes its approach to hearings as follows:

Hearings aim to be informal, inclusive and non-adversarial. Given the nature of its work, the [MHT] considers that this is the best way to achieve both fairness and efficiency, balancing the need to ensure that questions of liberty are dealt with appropriately and thoroughly, while remaining mindful of not disrupting the therapeutic relationship between patients and their treating teams.⁸⁴⁹

After hearing the evidence and any submissions, the MHT will stand down to deliberate and will call the parties back into the room to give its decision and reasons orally. A treatment order is made following 92.2% of all hearings⁸⁵⁰ (see Table 5 below for a breakdown).

Table 5: Orders made at MHT hearings by hearing type in 2014-2015⁸⁵¹

Hearing type	Order revoked	ITO made	CTO made
28 day TTO hearing	251 (8.6%)	1591 (54.8%)	1060 (36.5%)
Application for treatment order by psychiatrist	98 (6.0%)	243 (14.8%)	1304 (79.3%)
Application for revocation by patient	82 (9.9%)	434 (52.2%)	315 (38.0%)
Post variation to ITO	43 (7.4%)	424 (73.0%)	114 (19.6%)

837 MHT, 2014/2015 annual report, above n 15, 16, 17.

838 Ibid 17 (21-26 weeks).

839 Light, above n 49.

840 This compares to 0.75 ECT treatments per 10,000 residents in New Zealand and 1.8 in the UK: Leiknes, von Schweder and Høie, above n 15.

841 Office of the Chief Psychiatrist, above n 11, 34. This includes both voluntary and involuntary ECT.

842 MHT, 2014/2015 annual report, above n 15, 20.

843 If the hearing relates to ECT or neurosurgery for mental illness, a psychiatrist member rather than a medical member must be on the panel: Mental Health Act 2014 (Vic) s 178.

844 MHT, 2014/2015 annual report, above n 15, 11.

845 Ibid 25.

846 Ibid 13.

847 The report forms are available on the MHT’s website: <<http://www.mht.vic.gov.au/forms-and-publication/tribunal-forms/>>.

848 Mental Health Act 2014 (Vic) s 181.

849 MHT, 2014/2015 annual report, above n 15, 13. The MHT has also produced A Guide to Solution-Focused hearings in the Mental Health Tribunal, above n 283, and A Guide to Procedural Fairness in the Mental Health Tribunal, above n 260.

850 MHT, 2014/2015 annual report, above n 15, 17.

851 Ibid 18.

Mental health legal service providers

Victoria Legal Aid ('VLA') is the primary provider of mental health legal services in Victoria and provided over 93% of all legal representation before the MHT in 2014-2015 (over 1100 hearings).⁸⁵² VLA and its Mental Health and Disability Law sub-program ('MHDL') are described in Appendix 1.

The other specialist mental health legal service in Victoria is the Mental Health Legal Centre ('MHLC'), a small community legal centre that 'provides a free and confidential legal service to anyone who has experienced mental illness in Victoria where their legal problem relates to their mental illness'.⁸⁵³ The MHLC has been operating since 1987 but, in 2013, the majority of its funding was redirected to VLA's MHDL program. In 2014-2015, it provided legal representation in 40 MHT hearings (3% of all representation).⁸⁵⁴

Other lawyers (such as those in private firms) collectively provided the remaining 4% of legal representation before the MHT in 2014-2015 (36 hearings).⁸⁵⁵ While there is nothing preventing private lawyers from seeking funding from VLA to provide MHT representation to people who meet the guideline for legal assistance, a total of only \$622 was claimed by private lawyers for MHT representation in 2014-2015.

Non-legal mental health advocacy services

In August 2015, VLA's independent mental health advocacy ('IMHA') service commenced operation. IMHA provides non-legal advocacy for compulsory patients and people at risk of being made a compulsory patient.⁸⁵⁶ The service was funded by the Department of Health and Human Services to support the reform objectives of the new MHA.

A range of other organisations, such as the Victorian Mental Illness Awareness Council,⁸⁵⁷ also provide advocacy for people experiencing mental illness.

⁸⁵²
Ibid 26.

⁸⁵³
See MHLC website
<http://www.communitylaw.org.au/clc_mentalhealth/cb_pages/the_legal_centre.php>.

⁸⁵⁴
MHT, 2014/2015 annual report, above n 15, 26.

⁸⁵⁵
Ibid 26.

⁸⁵⁶
For more information, see IMHA website
<<http://www.imha.vic.gov.au>>.

⁸⁵⁷
See <<http://www.vmiac.org.au>>.

APPENDIX 4: UK LAW SOCIETY'S ADVICE ON REPRESENTING CLIENTS WITHOUT CAPACITY BEFORE THE MHT

This extract is taken directly from the Law Society's Practice Note on representation before mental health tribunals.⁸⁵⁸

You must assume that your client has capacity to give you instructions unless the contrary is established. Nevertheless, there will be occasions on which you will not be able to accept instructions directly, or by way of a referral, because the client lacks capacity to instruct you. You may form this view if, for example, the client is profoundly learning disabled and cannot appreciate that they are detained under the Mental Health Act.

If you think that your client lacks capacity to instruct you then you cannot act for this client unless either:

- you are instructed by a properly authorised third party, such as a court-appointed deputy or the donee of a power of property and affairs power of attorney, or
- the relevant tribunal has appointed you to act under the First-tier Tribunal Rules, Tribunal (Wales) Rules or the Upper Tribunal Rules...

[T]he tribunal can appoint a solicitor for a patient if satisfied that the patient lacks capacity to appoint a representative. This is not the same as 'capacity to litigate'. There will be a few patients who lack capacity to litigate at a tribunal but who have capacity to appoint a representative.

The appointment by the tribunal operates as a retainer for the client.

An appointment by the tribunal does not mean that you are also appointed to act as the client's litigation friend: there is no provision for such an appointment within the rules. You should not automatically assume that guidance that may have been prepared for the use of a litigation friend in other court proceedings applies to you as a representative.

Once appointed by the tribunal you have a heightened responsibility to identify and then to act in the interests of the client. The duty to act in the client's best interests is set out in Principle 1 of the SRA Code 2011 and applies to clients with or without litigation capacity.

In our view the client's interest in a fair hearing to determine the lawfulness of their detention is paramount. When your client lacks litigation capacity, you will not take instructions in the same way that you would in respect of a client with capacity. Instead you must do your best to ascertain their wishes and feelings. You must give weight to the wishes that your client expresses.

The closer the patient is to having capacity, the greater the weight you must give to their wishes in seeking to formulate and advance submissions on their behalf. Nonetheless, you remain under the same duty to the tribunal to advance only submissions which are properly arguable as if your client had capacity (see *Buxton v Mills-Owen* and Section 4.1 Clients with capacity).

There are likely to be few cases where a client who is able to express their wish to be discharged by a tribunal will be assessed as lacking capacity to instruct you. Similarly, where a client without litigation capacity tells you they wish to be discharged from hospital, there will be few cases it will not be appropriate to argue for their discharge. This is because of the over-riding importance of the client's right under Article 5(4) to challenge the lawfulness of their detention - a right that exists without the detained individual needing to show that they have any particular chance of success in obtaining their release - see *Waite v UK* (2003) 36 EHRR 54.

⁸⁵⁸
Above n 185, [4.2].

Where the client lacks the ability to express their wishes you should:

- ensure that the tribunal receives all relevant material so that it can determine whether the criteria for continued detention are satisfied
- test the criteria for continued detention
- remember your client's right to treatment in the least restrictive setting and alert the tribunal to possible alternatives to detention under the [MHA] such as [CTOs] and guardianship
- In the case of a patient who is unable to consent to be detained for purposes of assessment or treatment in hospital but appears to be compliant, you may wish to consider whether the DoLS regime under Schedule A1 to the [MCA] might provide a better and less restrictive way of ensuring that your client receives treatment or assessment in hospital: see *AM v SLAM NHS Foundation Trust* [2013] UKUT 365 (AAC).

You should not automatically argue for discharge if you are unable to ascertain the patient's wishes, but you are obliged to test the criteria for detention.

Separate considerations arise if the client is adamant that they do not wish to be represented by you, notwithstanding your appointment by the tribunal under Rule 11(7)(b), the tribunal having assessed the client as lacking capacity to appoint a representative.

If on meeting the client you think that he or she has capacity to appoint you then you should alert the tribunal and ask for the appointment to be discharged. It is then the client's decision whether to instruct you or not.

If you consider that the client lacks capacity to instruct you but think the client is hostile to being represented by you, then in some cases you should consider informing the tribunal and requesting the appointment to be discharged. This may be appropriate where:

- attempting to represent the client would cause them distress or interfere with their ability to participate in proceedings
- the client's hostility is such that you cannot fulfil your professional obligations to them, or
- continuing to attempt to represent the client puts your safety at risk and the risk cannot be managed using local policies at the unit where the client is detained.

APPENDIX 5: CURRENT CRITERIA FOR UK LEGAL AID FUNDING FOR JUDICIAL REVIEW AND BREACHES OF HUMAN RIGHTS MATTERS

In order to approve legal aid funding for ‘full representation’ in:

- Public law claims, including judicial review and habeas corpus matters;
- Torts or other claims for damages in respect of a serious breach of ECHR rights; and
- Claims of abuse of position or powers by a public authority,⁸⁵⁹

the director of legal aid casework must be satisfied the following are met:

- The ‘**standard criteria**’ for determinations for legal representation’:⁸⁶⁰
 - (a) ‘The individual does not have access to other potential sources of funding (other than a conditional fee agreement) from which it would be reasonable to fund the case;
 - (b) ‘The case is unsuitable for a conditional fee agreement;
 - (c) ‘There is no person other than the individual, including a person who might benefit from the proceedings, who can reasonably be expected to bring the proceedings;
 - (d) ‘The individual has exhausted all reasonable alternatives to bringing proceedings including any complaints system, ombudsman scheme or other form of alternative dispute resolution;
 - (e) ‘There is a need for representation in all the circumstances of the case including—
 - (i) ‘The nature and complexity of the issues;
 - (ii) ‘The existence of other proceedings; and
 - (iii) ‘The interests of other parties to the proceedings; and
 - (f) ‘The proceedings are not likely to be allocated to the small claims track.’
- The ‘**proportionality test**’: ‘The likely benefits of the proceedings to the individual and others justify the likely costs, having regard to the prospects of success and all the other circumstances of the case’;⁸⁶¹ and
- The ‘**prospects of success test**’:⁸⁶²
 - (a) ‘The prospects of successfully obtaining the substantive order sought in the proceedings are very good, good or moderate; or
 - (b) ‘The prospects of success, or of successfully obtaining the substantive order sought in the proceedings, are borderline or poor [defined as a less than 50% chance] but it is—
 - (i) ‘Necessary for the Director to determine that the criterion in this paragraph is met to prevent a breach of—
 - (aa) ‘The individual’s [ECHR] rights; or
 - (bb) ‘Any rights of the individual to the provision of legal services that are enforceable EU rights; or
 - (ii) ‘Appropriate for the Director to determine that the criterion in this paragraph is met, in the particular circumstances of the case, having regard to any risk that a failure to make such a determination would be such a breach.’

⁸⁵⁹
An act or omission by a public authority will not constitute an abuse of its position or powers unless it is ‘deliberate or dishonest, and results in harm to a person or property that was reasonably foreseeable’: *Legal Aid, Sentencing and Punishment of Offenders Act 2012* (UK) sch 1, part 1, para 22(1).

⁸⁶⁰
Civil Legal Aid (Merits Criteria) Regulations 2013 (UK) regs 39, 53, 56(1)(b), 58(1)(a).

⁸⁶¹
Ibid regs 8, 56(2)(b), 58(2).

⁸⁶²
Ibid regs 43, 56(2)(c) and (3), 58(1)(a).

⁸⁶³
Ibid regs 53, 56(2)(a).

⁸⁶⁴
Legal Aid, Sentencing and Punishment of Offenders Act 2012 (UK) sch 1, part 1, para 19(3)-(4).

⁸⁶⁵
Civil Legal Aid (Merits Criteria) Regulations 2013 (UK) regs 18(3), 55, 57.

The following criteria must also be met in relation to public law claims:⁸⁶³

- The act, omission or other matter complained of appears to be susceptible to challenge;
- There are no alternative court or tribunal proceedings which are available to challenge the act, omission or other matter, except where the director considers that such proceedings would not be effective in providing the remedy that the individual requires; and
- The individual has sent a letter before claim to the proposed defendant (except where this is impracticable) and, where such a letter has been sent, the proposed defendant has been given a reasonable time to respond.

Finally, a judicial review matter must ‘have the potential to produce a benefit for the individual, a member of the individual’s family or the environment’, unless the potential to benefit ceases after legal services have been provided.⁸⁶⁴

Funding is also available under less stringent criteria for ‘investigative representation’ in relation to these types of matters,⁸⁶⁵ to allow exploration of the strength of the contemplated proceedings.

APPENDIX 6: MENTAL CAPACITY ACT 2005 (UK) AND THE ‘DEPRIVATION OF LIBERTY SAFEGUARDS’

England introduced a new statutory scheme – the ‘deprivation of liberty safeguards’ (‘DOLS’) – into the *Mental Capacity Act 2005* (UK) (‘MCA’), to close the Bournemouth gap. Since April 2009, the DOLS scheme requires hospitals (whether public or private)⁸⁶⁶ and care homes to apply to their local authority for authorisation where they are objectively depriving a person of their liberty and they lack the mental capacity to provide informed consent to those arrangements. The circumstances in which the service is under a duty to apply are set out in Schedule A1 of the MCA.

Note that if the person objects to the deprivation of their liberty, they will instead be formally detained under the MHA (provided they otherwise meet the criteria).

Upon an application for authorisation, the DOLS team at the local authority will consider assessments done by both a mental health assessor and a ‘best interests assessor’ and determine whether to grant the authorisation, having regard to the following statutory requirements:⁸⁶⁷

- The **age requirement** will be met if the person is aged 18 or older.⁸⁶⁸
- The **mental health requirement** will be met if the person has a mental disorder as defined in the MHA (disregarding any exclusions relating to learning disabilities).⁸⁶⁹
- The **mental capacity requirement** will be met if the person ‘lacks capacity in relation to the question [of] whether or not he [or she] should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment’.⁸⁷⁰
- The **best interests requirement** will be met if all of the following conditions are met:⁸⁷¹
 - The person is, or is to be, a detained resident.
 - It is in the person’s ‘best interests’⁸⁷² to be a detained resident.
 - It is necessary for the person to be a detained resident in order to prevent harm to them.
 - Detaining the person is a proportionate response to:
 - The likelihood of the person suffering harm; and
 - The seriousness of that harm for them.
- The **eligibility requirement** will be met if the person is not otherwise ineligible under the MCA.⁸⁷³
- The **‘no refusals’ requirement** will be met unless the person has made a valid advance directive which is relevant to some or all of the relevant treatment, or it would conflict with a valid decision made by an appointed substitute decision-maker.⁸⁷⁴

A person must be appointed as the ‘relevant person’s representative’ as soon as practicable after an authorisation is given.⁸⁷⁵ This may be a friend or family member. If there is no one suitable to take on this role, the supervisory body will appoint someone to perform this role in a professional capacity.

A person subject to a DOLS authorisation or their representative may request the service or the local authority to review the authorisation at any time.⁸⁷⁶

The person subject to the DOLS assessment or their representative may apply as of right (without needing the court’s permission) to the Court of Protection to challenge the authorisation. Other parties must seek the court’s permission to challenge an authorisation.

The Court of Protection may then determine any question relating to the following matters:

- Whether the person meets one or more of the qualifying requirements;
- The period during which the authorisation is to be in force;
- The purpose for which the authorisation is given; and
- The conditions to which the authorisation is subject.⁸⁷⁷

Accordingly, the Court of Protection does not determine whether the person should or should not be deprived of their liberty per se but instead makes a determination of their best interests, the corollary of which may be a deprivation of their liberty which thus requires additional safeguards.⁸⁷⁸

Appeals from decisions of the Court of Protection are heard in the Court of Appeal or Supreme Court.

⁸⁶⁶ *Mental Capacity Act 2005* (UK) sch A1, [175(1)].

⁸⁶⁷ MHLA, *Law Society accreditation scheme training coursebook*, above n 74, 55.

⁸⁶⁸ *Mental Capacity Act 2005* (UK) sch A1, [13].

⁸⁶⁹ *Ibid* sch A1, [14].

⁸⁷⁰ *Ibid* sch A1, [15].

⁸⁷¹ *Ibid* sch A1, [16].

⁸⁷² How best interests is to be understood and determined is guided by *Mental Capacity Act 2005* (UK) s 4 and sch A1, [39]–[45].

⁸⁷³ *Ibid* sch A1, [17].

⁸⁷⁴ *Ibid* sch A1, [18]–[20].

⁸⁷⁵ *Ibid* sch A1, [139].

⁸⁷⁶ *Ibid* sch A1, [102]–[103].

⁸⁷⁷ *Ibid* s 21A(2).

⁸⁷⁸ *Re NRA* [2015] EWCOP 59, [73].

APPENDIX 7: SURVEY OF ORGANISATIONS THAT ENGAGE IN STRATEGIC ADVOCACY

This appendix provides some background information about the scope and operation of the organisations discussed in Chapter 4, especially Part 4C, and some further information about their strategic advocacy activities.

Disability Rights New York

Disability Rights New York (**'DRNY'**) was designated as the protection and advocacy (**'P&A'**) agency⁸⁷⁹ for New York state on 1 June 2013, and is accordingly still 'finding its feet' a bit.⁸⁸⁰ In less than two years, it went from a single, seven-person law office providing regional P&A services to almost 50 employees covering the entire state, opening three new offices, and they are still expanding their infrastructure.⁸⁸¹ It is primarily federally funded but it is able to raise funds in other ways, including contracts, state and/or local funds and donations.⁸⁸²

DRNY comprises eight federal programs:

- P&A for Individuals with Developmental Disabilities (**'PADD'**);
- P&A for Individuals with Mental Illness (**'PAIMI'**);
- P&A for Individual Rights;
- P&A for Assistive Technology;
- Client Assistance Program;
- P&A for Voting Access;
- P&A for Individuals with Traumatic Brain Injuries; and
- P&A for Beneficiaries of Social Security.

Each program has separate staff. While initially they operated essentially in silos, there is now more crossover and interaction between the programs.⁸⁸³ For instance, Jennifer Monthie described how both the PADD and PAIMI programs are examining the treatment of their respective clients in prisons.⁸⁸⁴ Many of the programs have several joint projects together and lawyers on the different programs regularly consult each other about questions that arise in cases.⁸⁸⁵

DRNY engages in a wide range of work types, including information, advice, individual case work, court advocacy, strategic case work, community education and policy and law reform activities.⁸⁸⁶ It describes all of its work as being legal work,⁸⁸⁷ and it does not employ any social workers.

Eligibility for services is set by the federal funding for each different program. While a person's disability does not, in and of itself, make them eligible for assistance with any legal issue they may have, DRNY is not restricted to only providing assistance in mental health and disability law matters.⁸⁸⁸ Instead, DRNY will take on legal issues if they are *connected* to the person's disability (for instance, they may take on a family law matter if there are issues of disability discrimination).⁸⁸⁹ Although P&As were predominantly set up to respond to conditions in institutions, they also deal with community-based issues which affect the same cohort (for instance, the policing of people with mental illness).⁸⁹⁰

DRNY's PAIMI program does not represent individuals at mental health hearings because the MHLS does this work, but they may assist an MHLS client with other matters and/or refer matters to the MHLS to look into. Passing a client on to another service like the MHLS will mean that DRNY cannot then count them as an individual client, which may impact on DRNY's funding and profile. Alison Lynch identified it as a potential weakness that staff may be influenced by these considerations when considering whether to refer a client.⁸⁹¹

Client intake mostly occurs through direct self-referral.⁸⁹² New Yorkers contact DRNY through telephone (including 1800 and TTY lines), email, mail or walking into DRNY.⁸⁹³ DRNY does not receive as many referrals as it would like from services,⁸⁹⁴ perhaps reflective of its relatively new status. The PADD also uses an 'attorney-of-the-day' model. The attorney is assigned to the intake department and, along with the intake director, program directors and general counsel, will review complaints of abuse and neglect immediately.⁸⁹⁵

⁸⁷⁹ For an explanation, see box 'About the US protection and advocacy system' in Part 4C above.

⁸⁸⁰ Alison Lynch.

⁸⁸¹ Jennifer Monthie.

⁸⁸² Mark Murphy.

⁸⁸³ Alison Lynch.

⁸⁸⁴ DRNY litigated a case on behalf of prisoners with mental illness in New York State, which resulted in some changes to state law. Their correctional system has started to implement some of these changes for individuals with intellectual and developmental disabilities as well and DRNY is monitoring the rollout of these changes.

⁸⁸⁵ Alison Lynch.

⁸⁸⁶ Jennifer Monthie, Mark Murphy.

⁸⁸⁷ Jennifer Monthie.

⁸⁸⁸ Alison Lynch.

⁸⁸⁹ Ibid.

⁸⁹⁰ Ibid.

⁸⁹¹ Ibid.

⁸⁹² Ibid.

⁸⁹³ Jennifer Monthie, Mark Murphy.

⁸⁹⁴ Alison Lynch.

⁸⁹⁵ Jennifer Monthie.

DRNY has been able to meet demand to ensure that every person who has contacted DRNY obtains at least some assistance.⁸⁹⁶

Each request for service is assessed on an individual case by case basis. The intake department works to collect information from the client seeking service and an attorney reviews the legal issues to determine if the matter falls within priorities and whether DRNY can assist. Every person contacting DRNY either obtains information and referral, technical assistance or direct advocacy. The individual may receive a combination of all three... [T]he matter is assigned to the program director (also an attorney) for review and determination if the matter will be assigned for direct representation. Finally the matter is assigned to an attorney or advocate within the program.⁸⁹⁷

Individual lawyers at PAIMI have a lot of autonomy in their work and are trusted to pick and respond to issues as they see appropriate.⁸⁹⁸

Each of the eight programs is directly overseen by a program director, who is an attorney. All programs are further overseen by DRNY's general counsel/legal director and their executive director, who are also both attorneys. The program director is responsible for the litigation within their program and the general counsel/legal director has general responsibility for all litigation brought by DRNY. The litigation tasks are spread among all attorneys within DRNY⁸⁹⁹ and are generally done collaboratively by small teams.⁹⁰⁰ DRNY also often co-counsels with other law firms, which helps extend their resources and reach.⁹⁰¹

DRNY conducts monitoring visits at a wide variety of facilities in New York State that provide services to people with disabilities. Mark Murphy explained that 'a primary mission of [DRNY] is to investigate allegations of abuse and neglect, so this requires visits to many different types of facilities'. DRNY focuses on those settings where MHLS does not have jurisdiction, for example, prisons and jails.⁹⁰²

As DRNY operates only three offices across New York state (which is about 60% of the size of Victoria despite having a population the same as Australia), a lot of its budget is taken up with travel costs – mostly doing visits to individuals who have requested assistance but also when going on week-long 'tours' to various facilities, for instance when they are gathering information for a test case.⁹⁰³ Jennifer Monthie reported that DRNY has conducted outreach in each of New York State's 62 counties this year to expand New York's understanding of the P&A system. Mark Murphy also noted that DRNY 'spend[s] a substantial amount of resources on outreach, including doing trainings, attending conferences to distribute materials both substantive and about DRNY'. DRNY has trained thousands of individuals with disabilities, family members and other interested individuals in the last year. These groups were targeted for education by DRNY because they are often the first to learn about problems that their clients face and can then contact DRNY to address these problems.⁹⁰⁴

DRNY is required under federal law to be independent from the service delivery system and 'takes this responsibility very seriously'.⁹⁰⁵ Mark said their relationship with the facilities is 'generally business-like – they tolerate us because they have to,⁹⁰⁶ although we often have to fight to establish our right to access facilities and/or client records'. For instance, they have had to engage in litigation against entities that have denied them access to facilities. Mark also said that, in his experience, 'many staff are wary about talking to lawyers'. He said that the provision of information about rights and the availability of P&A services by facilities 'varies greatly, but is usually nowhere near what it should be'. Jennifer agreed, saying that some promote and seek out DRNY's services to provide training to residents while others are 'leery of our presence'. Noting the DRNY has only been the designated P&A since 2013, Jennifer felt that '[s]ome facilities have responded quickly to our presence and some have not', and she felt that more time was needed to answer whether this will change.

896
Ibid.

897
Ibid.

898
For instance, a lawyer can send a letter of complaint to a hospital without it being checked by a manager, but would consult with a manager before filing any court action: Alison Lynch.

899
Jennifer Monthie.

900
Mark Murphy.

901
Ibid.

902
Jennifer Monthie.

903
Alison Lynch.

904
Jennifer Monthie.

905
Ibid.

906
Federal law authorising P&A work contains specific provisions about access rights.

MFY Legal Services, Inc.

MFY Legal Services, Inc. ('MFY') commenced in 1963 and 'provides free legal assistance to residents of New York City on a wide range of civil legal issues, prioritiz[ing] services to vulnerable and under-served populations, while simultaneously working to end the root causes of inequities through impact litigation, law reform and policy advocacy'.⁹⁰⁷ In 2014, it handled 9,423 cases benefiting over 17,000 people, and worked with more than 400 pro bono attorneys and other volunteers on 2500 individual cases and class actions benefiting 23,500 people.⁹⁰⁸ It receives two-thirds of its funding from government.

MFY operates a number of specific programs. Around 27% of its budget goes into programs for people with disabilities,⁹⁰⁹ including the mental health law project and the adult homes advocacy project.

Mental health law project

The mental health law project was established in 1983 and provides legal services, particularly related to housing and social security benefits, to people with mental illness to ensure they have the supports they need in order to live in the community. MFY describes a clear connection between social stressors, mental health and legal help:

Mental health consumers, no less than other populations, regularly face legal battles to maintain housing, secure an adequate income, and live with the full dignity and civil rights to which they are entitled. For persons struggling with severe mental illnesses, these legal battles are another stressor that can ultimately lead to deterioration of mental health status, hospitali[s]ation, and homelessness. By providing civil legal assistance to mental health consumers, MFY stands as a bulwark against crisis – preventing homelessness, loss of income and loss of civil rights so that mental health consumers can maintain stability within their chosen community.⁹¹⁰

The project's supervising attorney, Mallory Curran, explained:

Our goal is to actually help people remain in the community and be integrated as much as possible into the community, and we believe that many people with mental illness need legal care to compliment the mental health care that they receive in order to be as healthy as possible. So, we focus on preserving housing, stabilising income, promoting employment and supporting recovery...

Our work is really on the prevention side so if someone's already in the hospital we're trying to get them out as soon as possible. If someone's not in the hospital we're trying to help and keep them out. We're trying to reduce stressors so that they are able to really focus on their care rather than their terror that they're about to be evicted or the fact that they all of a sudden have no income.⁹¹¹

The Project, which employs eight lawyers and three paralegals, works closely with hospitals, providing in-reach advice services and having well-established referral networks.⁹¹²

We have a relationship with all of the inpatient psychiatric services in the public hospitals... So when they have a patient who is in the hospital and when there is some... legal barrier to their release, they are in touch with us. We have a direct phone number for each of those hospitals to reach an attorney directly... [O]ften [it is] a social worker or a psychologist or a psychiatrist who is contacting us to say this landlord is saying, 'This person can't come home' and then we say, 'That's not right' and then we help them in a variety of ways. We communicate with the landlord and often are just able to get the person to be able to be released or go home.⁹¹³

⁹⁰⁷ MFY, 'About MFY' <<http://www.mfy.org/about/about-mfy/>>.

⁹⁰⁸ MFY, *MFY Legal Services, Inc. 2014 Annual Report* (2015).

⁹⁰⁹ Ibid.

⁹¹⁰ MFY, 'Mental Health Law Project' <<http://www.mfy.org/projects/mental-health-law-project/>>.

⁹¹¹ Mallory Curran.

⁹¹² Ibid.

⁹¹³ Ibid.

MFY is also exploring more collaborative medico-legal partnerships to more effectively identify and respond to legal needs:

For years I think we were on a parallel track, working with the same people in the community but not communicating with each other... [With the new program we are establishing, we are] trying to keep people out of hospitals with some very intensive home-based services that involve engaged family members and friends and so forth, where we could potentially be a part of the team that goes to the home and works to identify legal needs. Sometimes there are obvious legal needs but other times there are things that people don't know a lawyer can help them with. So I think it's really important to have those partnerships and go meet people where they are because I think it's unrealistic to expect everyone to know that a lawyer could be the one to help them.⁹¹⁴

MFY recently established a medico-legal partnership with Bellevue Hospital's Child and Adolescent Psychiatry department, where an MFY lawyer provides on-site legal assistance to children and young people with mental illness and their families to navigate the complex educational and social security bureaucracy so that they can receive appropriate supports.⁹¹⁵

[The lawyer is] at Bellevue two full days a week and she participates in rounds, so when they're talking about different patients and thinking about discharge planning, which is started as soon as the patient is admitted, she is there saying, 'Have you thought about this?' or 'Why don't you refer that family to me?'⁹¹⁶

Mallory Curran explained that whether the medical services or hospitals are responsive and engaged depends on the mission of the entity:

If the mission of the institution is to serve the community in all sorts of creative ways then they tend to be more excited about having lawyers on the team, or a community health centre or a place that has a mission to serve people on a lower income, or does serve people of low income, tends to be more welcoming than places [serving] fewer lower income patients. It was new 15 years ago – there were only a handful of medical legal partnerships, but now there are about 300 and so it's become also more common. I think the ones at the beginning took more of a risk and were worried that they would get a whole lot of medical malpractice cases which has not happened.

Adult homes advocacy project

Building on the work of the mental health law project, MFY secured state funding in 1992 to develop the adult homes advocacy project due to its concerns about people being warehoused in terrible conditions. There are over 40 adult homes in New York city, each housing 200-400 people. They provide a range of services including food, medication management, case management and transport to appointments and are all privately run for profit.

Adult homes in New York State were originally designed to house "the frail elderly," not people with psychiatric disabilities. They became a place for people with mental illness to live and receive services when the State began to deinstitutional[is]e its State psychiatric hospitals in the early 1970s, and State psychiatric hospitals began discharging patients directly into adult homes. As former [Office of Mental Health] Commissioner James Stone noted, adult homes developed because "community resources weren't up to speed with state operated bed reductions" resulting from deinstitutional[is]ation. Thirty years ago, New York State and New York City government reports referred to adult homes as "de facto mental institutions" and "satellite mental institutions." According to Linda Rosenberg, a former Senior Deputy Commissioner of [the Office of Mental Health] who worked in the State's mental health system from the early 1970s to 2004, [the Office of Mental Health's] approach to the community integration of people with severe mental health issues evolved over the years, and "it became increasingly clear that [adult homes] were neither desirable, nor would they really promote people's recovery and integration and full social inclusion" (citations removed).⁹¹⁷

914
Ibid.

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MFY, *MFY Legal Services, Inc. 2014 Annual Report* (2015).

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Mallory Curran. For more information about this partnership, see Aleah Gathings, 'MFY Legal Services, Inc.'s medical legal partnership with Bellevue Hospital Center: Providing legal care to children with psychiatric disabilities' (2014) 18(1) *Cuny Law Review* 1.

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Disability Advocates, Inc. v Paterson, 653 F. Supp. 2d 184, 197 (ED NY 2009).

The adult homes advocacy project ‘uses a lawyer-organiser model to defend the rights of residents with psychiatric disabilities and address the deplorable conditions that exist throughout the industry’.⁹¹⁸ It has had quite stable campaign priorities for a while, which are to:

- Promote least restrictive alternatives (following *Olmstead*);
- Prevent abuse, fraud, neglect and discrimination; and
- Improve facility oversight and administration.⁹¹⁹

It provides individual legal services for adult home residents but with ‘an emphasis on affirmative litigation and policy advocacy to bring about systemic reform’.⁹²⁰

The adult homes advocacy project also provides outreach community legal education, trying to visit each facility once a year to provide training to residents to understand their rights. As well as face-to-face training, they provide written information and conduct an impromptu legal advice clinic following the session. Their services are usually not well received by the managers of the adult homes. While visitor access regulations mean they cannot be denied entry if they want to enter to offer their services to residents, the New York Coalition for Quality Assisted Living (a trade association of adult home operators) attempted to issue guidelines to its members to limit lawyers’ access to residents and impede confidential visits. The New York State Court of Appeals sided with MFY and affirmed the right of lawyers and advocates to meet freely with residents of adult homes.⁹²¹

Judge David L. Bazelon Center for Mental Health Law

Founded in 1972, the ‘mission of the Judge David L. Bazelon Center for Mental Health Law is to protect and advance the rights of adults and children who have mental disabilities... [It] pursues a progressive mental health policy agenda, particularly at the federal level, to reform systems and programs to protect the rights of children and adults with mental disabilities to lead lives with dignity in the community’.⁹²²

In decades of landmark advocacy, the Bazelon Center has led the way in efforts to define and advance the rights of people with mental disabilities in many aspects of their lives. The Bazelon Center’s legal victories have been replicated by advocates across the country and have supported reforms at the federal, state and local levels. On the federal policy front, the Bazelon Center’s leadership in the mental health arena is reflected in laws and policies that today protect the rights of people with mental disabilities and fund critical services for them.⁹²³

The Bazelon Center engages in both litigation and policy activities to achieve its mission.

Mental Health Association of New York City

The Mental Health Association of New York City (‘MHA-NYC’) is a not-for-profit organisation that addresses mental health needs in New York City and beyond:

Through our three-part mission of service, advocacy and education, we identify unmet needs and develop culturally sensitive programs to improve the lives of individuals and families impacted by mental illness while promoting the importance of mental health.⁹²⁴

MHA-NYC’s education campaigns, while related, are separate to its advocacy and often take the form of discrete projects like suicide prevention.

Disability Rights International

Disability Rights International (‘DRI’) is a leading international human rights organisation dedicated to protecting the rights of people with disabilities. It focuses its energy on researching and documenting abuses against children and adults with disabilities, to great effect:

[DRI’s] reports have brought world attention to human rights violations in twenty-two countries of Eastern Europe, the Middle East, and the Americas. Our video clips have been broadcast on every continent and on CNN, ABC’s Nightline, NBC’s Dateline [and] BBC World News. [DRI] has been profiled in the New York Times Magazine and our advocacy campaigns have been supported by editorials in The New York Times and The Washington Post.⁹²⁵

⁹¹⁸ MFY, *Mobilising for justice since 1963*, above n 555, 8.

⁹¹⁹ Jota Borgmann.

⁹²⁰ Ibid.

⁹²¹ New York Coalition for Quality Assisted Living v MFY Legal Services, Inc., 17 NY3d 886 (2011).

⁹²² Bazelon, ‘Who we are’ above n 638.

⁹²³ Bazelon, ‘Our history’, above n 591.

⁹²⁴ MHA-NYC, ‘Mission’ <<http://www.mhaofnyc.org/who-we-are/mission/>>.

⁹²⁵ DRI, ‘Our work’, above n 665.

Liberty

Liberty is an NGO based in England.

Liberty is also known as the National Council for Civil Liberties. Founded in 1934, [it is] a cross party, non-party membership organisation at the heart of the movement for fundamental rights and freedoms in the UK.

[It] promote[s] the values of individual human dignity, equal treatment and fairness as the foundations of a democratic society.

Liberty campaigns to protect basic rights and freedoms through the courts, in Parliament and in the wider community. [It does] this through a combination of public campaigning, test case litigation, parliamentary work, policy analysis and the provision of free advice and information.⁹²⁶

Mental Disability Advocacy Centre

[The Mental Disability Advocacy Centre ('MDAC')] is an international human rights organisation that uses the law to secure equality, inclusion and justice for people with mental disabilities worldwide. [It] operate[s] at the global level as well as regional and domestic levels in Europe and Africa.

MDAC is headquartered in Budapest, Hungary and was registered as a foundation by the Budapest Capital Court (registration number 8689) in November 2002. The Open Society Foundations (OSF) founded MDAC and continues to be one of its donors. [It has] participatory status with the Council of Europe and is entitled to lodge collective complaints under the Revised European Social Charter. It [also] has special consultative status with [the United Nations Economic and Social Council].⁹²⁷

MDAC 'has been involved in many of the significant developments [in mental health and disability rights in Europe] in the last ten years'.⁹²⁸ Prior to MDAC's involvement, few people had ever really considered that recognition of people with disabilities before the law was a human rights issue.⁹²⁹ Questions about capacity and guardianship had never been asked before in Bulgaria, the Czech Republic, Russia, Croatia and Serbia (the counties in which MDAC has been working the longest).⁹³⁰ Yet, over a relatively short period of time, with MDAC closely engaged, this has occurred.⁹³¹

Társaság A Szabadságjogokért – Hungarian Civil Liberties Union

The Hungarian Civil Liberties Union ('HCLU') is a non-profit NGO that was established in Budapest, Hungary, in 1994.

[It] is a Hungarian human rights watchdog working independently of political parties, the state or any of its institutions. The HCLU's aim is to promote the case of fundamental rights and principles laid down by the Constitution of Hungary and by international conventions. Generally, it has the goal of building and strengthening civil society and the rule of law in Hungary and in the [Central and Eastern European] region. Since the HCLU is an independent non-profit organi[s]ation, its financial resources are mostly provided by foundations and by an increasing number of private persons.

The HCLU strives to educate citizens about their basic human rights and freedoms, and takes stand against undue interference and misuse of power by those in positions of authority.⁹³²

One of the HCLU's programs is the disability rights program, led by Tamás Verdes.

The disability rights program focuses on assisting mentally challenged, intellectually disabled and severely handicapped people. The aim of the program is to help them to live their life as an equal citizen and as a recogni[s]ed member of their community. The most important goal is to eliminate totalitarian mass institutions and, in parallel, to develop programs in the community that promote integration; to reform the guardian system, that is, to advocate supported decision-making; to fight legislation that attempts to restrict the voting rights and to promote the right to education for children with mental disabilities.⁹³³

926
Liberty, 'Who we are'
<<https://www.liberty-human-rights.org.uk/who-we-are>>.

927
MDAC, 'About'
<<http://www.mdac.org/en/about>>.

928
Steven Allen.

929
Ibid.

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Ibid.

931
Ibid.

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HCLU, 'About us'
<<http://tasz.hu/en/about-us>>.

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HCLU, 'Disability rights'
<<http://tasz.hu/en/disability-rights>>.

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ACRONYMS

ACLU	American Civil Liberties Union
ADA	Americans with Disabilities Act
AMHP	Approved mental health professional (England)
BPC	Bronx Psychiatric Center (New York)
CCG	Clinical Commissioning Group (England)
CCQI	College Centre for Quality Improvement at the Royal College of Psychiatrists (England)
CNYPC	Central New York Psychiatric Center
CPA	Care programme approach (England)
CPT	Council of Europe Committee for the Prevention of Torture
CQC	Care Quality Commission (England)
CQUIN	Commissioning for Quality and Innovation (England)
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CTO	Community treatment order (England/Victoria)
DCPDS MHD	Mental Health Division of the Public Defender Service (Washington DC)
DOLS	Deprivation of liberty safeguards (England)
DRI	Disability Rights International
DRNY	Disability Rights New York
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
ECT	Electroconvulsive treatment
ESIF	European Structural and Investment Funds
EU	European Union
FTE	Full-time equivalent
HCLU	Hungarian Civil Liberties Union (Társaság A Szabadságjogokért)
IAFMHS	International Association of Forensic Mental Health Services
IALMH	International Academy of Law and Mental Health
IMCA	Independent mental capacity advocates/advocacy (England/Victoria)
IMHA	Independent mental health advocates/advocacy (England/Victoria)
ITO	Inpatient treatment order (Victoria)

MCA	Mental Capacity Act (England)
MDAC	Mental Disability Advocacy Centre (Hungary)
MHA	Mental Health Act (England/Victoria)
MHA-NYC	Mental Health Association of New York City
MHDL	Mental Health and Disability Law program (Victoria)
MHLA	Mental Health Lawyers Association (England)
MHLC	Mental Health Legal Centre (Victoria)
MHLS	Mental Hygiene Legal Service (New York)
MHT	Mental Health Tribunal (England/Victoria) In England, its formal name is the 'First-Tier Tribunal (Health, Education and Social Care Chamber) (Mental Health)'
NDIS	National Disability Insurance Scheme (Australia)
NDRN	National Disability Rights Network (US)
NHS	National Health Service (England)
NGO	Non-government organisation
NJOPD MHA	Division of Mental Health Advocacy at the Office of the Public Defender (New Jersey)
NPM	National preventive mechanism
P&A	Protection and Advocacy system (US)
PADD	Protection and Advocacy for Individuals with Developmental Disabilities (US)
PAIMI	Protection and Advocacy for Individuals with Mental Illness (US)
SHU	Special housing units (US)
SOAD	Second opinion appointed doctor (England)
TJ	Therapeutic jurisprudence (see glossary)
TTO	Temporary treatment order (Victoria)
US	United States of America
VCAT	Victorian Civil and Administrative Tribunal
VLA	Victoria Legal Aid
VLRC	Victorian Law Reform Commission

GLOSSARY

Administrative decision-makers	Most mental health laws establish various roles and positions (such as ‘authorised psychiatrist’ or ‘responsible clinician’) and give the people occupying those roles, usually psychiatrists or senior hospital administrators, the administrative (rather than judicial) power to make certain decisions in relation to compulsory patients. In this report, the people <i>other than tribunal members</i> who are empowered under mental health laws to make these decisions are collectively referred to as administrative decision-makers.
Bournewood gap	A gap in the law in which a person is deprived of their liberty in the absence of clear lawful authority because, although the person does not resist their situation, they are considered to lack the mental capacity to give informed consent to it.
Charter	<i>Charter of Human Rights and Responsibilities Act 2006 (Vic)</i>
Closed environment	In this report, the term ‘closed environment’ is used to refer to any place where a person with a disability may be formally or informally detained, except prisons. Such places include hospitals, institutions, residential disability services and group homes. They vary significantly in terms of their levels of physical security (locked doors, high walls etc), with some relying only on staff and relational security to prevent people from leaving. By their very nature, closed environments and their internal activities are typically hidden from public view.
Code of Practice	<i>Mental Health Act 1983: Code of Practice</i> , Department of Health (UK)
Compulsory inpatient	A person who has been formally detained for compulsory treatment under a mental health law.
Compulsory treatment	In this report, the term ‘compulsory treatment’ refers to treatment which is administered to a person with a disability notwithstanding the person objects to it or has not provided informed consent. It is usually, though not always, ⁹³⁴ administered pursuant to a formal legal power.
CRPD Committee	United Nations Committee on the Rights of Persons with Disabilities
Informally detained	Drawing on the definition of ‘detain’ in s 3(1) of the <i>Disability Act 2006 (Vic)</i> , a person is ‘informally detained’ if they are subject to constant or near-constant supervision and restrictions on their freedom of movement in the absence of any clear legal authority permitting this.
Judicial decision-maker	In this report, the term ‘judicial decision-maker’ is used to refer to the person or people who are tasked with determining the outcome at a mental health hearing even though, in a strict legal sense, they may be exercising administrative power. In New York, the judicial decision-maker is a Supreme Court judge. In England and Victoria, a tripartite panel of tribunal members constitutes the judicial decision-maker.

⁹³⁴
For instance, a treating service may not seek legal authority to provide treatment to a person who is acquiescing or not resisting the administration of that treatment, notwithstanding the person lacks the mental capacity to provide informed consent to it.

Judicial review	An administrative law procedure in which a court reviews the lawfulness of a decision, act or omission of a tribunal, public authority or person exercising administrative power.
Lawyer	I have predominantly used the term 'lawyer' in this report to refer to a legal professional who is instructed by a client, advises them and conducts legal work (including court/tribunal representation) on their behalf, although 'solicitor' is more commonly used in England and 'attorney' in the US.
Litigation friend	A person appointed to conduct proceedings on behalf of a person asserted to lack capacity; they will provide instructions to the lawyer about how the case should proceed.
Mental health hearing	A court or tribunal hearing which is held to determine whether a person should (continue to) be subjected to compulsory treatment under a mental health law.
Mental health legal services	Legal services provided to individuals who are subjected to compulsory treatment under a mental health law.
Negative rights	Negative rights require the State to refrain from acting against a person in a particular way, such as the rights to liberty, to privacy and to be free from treatment without consent.
People with disabilities	In the context of this report, this term refers to people with, diagnosed with or alleged to have a mental illness or intellectual, cognitive or neurological disability, and does not include people with sensory or physical disabilities. Where relevant, I refer to specific disabilities. See box on p 2 for an explanation of why this definition has been adopted.
Positive rights	Positive rights impose obligations on the State to act, such as the rights to housing and to health care.
Section 2 patient	A person detained under s 2 of the MHA for assessment, and treatment following assessment, for up to 28 days (England).
Section 3 patient	A person detained under s 3 of the MHA for long-term treatment (England).
Strategic advocacy	Advocacy designed to improve laws and practices that negatively impact on people in a systemic way rather than just at an individual level.
Therapeutic jurisprudence	'TJ' is an interdisciplinary field of study which examines the impact of the law and the legal process on participants' mental health and wellbeing. It aims to promote laws and legal processes that promote therapeutic outcomes and minimise counter-therapeutic ones.

Treatment	'Treatment' is much broader than the administration of medication. It includes a broad range of psychological, behavioural and other interventions aimed at remedying or alleviating symptoms and/or reducing risk, including invasive treatments like ECT. Some treatments may cause debilitating and serious side effects
Upper Tribunal	The 'Upper Tribunal (Administrative Appeals Chamber)', which is the body that hears appeals from the MHT (England).

